VOL. 1 OCTOBER, 1927

OLD SERIES VOL. XII

THE PSYCHIATRIC QUARTERLY

(SUCCESSOR TO THE STATE HOSPITAL QUARTERLY)

PUBLISHED AT THE STATE HOSPITAL, UTICA, N. Y., BY STATE

Department of Mental

AT ALBANY, N. Y.

Entered as Second Class Matter at the Post Office

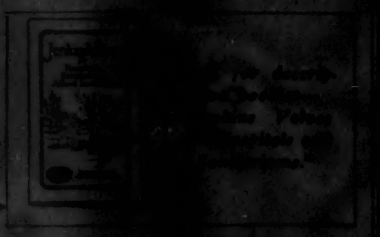


Fig. 71
Jenkins Bronze Fire Line Valve

Fig. 72
Jenkins
Valve

You can take service for granted

You can take long trouble free service for granted when you install a genuine Jenkins Valve. You can feel sure that its extra sturdiness will make for a result in lower maintenance costs.

The Jenkins "Diamond" mark, without which no valve is a genuine Jenkins Valve, is more than a mere identification mark. It is the mark of a valve well made of analyses-proved metals—a valve which has proved its worth in a wide-range safety test.

Jenkins Valves are Jenkins for practically every valve requirement. At supply houses everywhere.

JENKINS BROS.

Willett Street ..... New York, N. Y.
Columbia Avenue ..... Boston, Mass.
North Seventh Street ..... Philadelphia, Pa.
West Washington Boulevard ..... Chicago, Ill.

JENKINS BROS., LIMITED

Montreal, Canada ..... London, England

A few [illegible] hospitals using Jenkins Valves

Albany Hospital
St. Peter's [illegible]
Brooklyn Hospital
Brooklyn State [illegible]
Jewish Hospital, Brooklyn
Kings County [illegible]
Kingston Avenue [illegible]
L. I. College [illegible]
Buffalo State [illegible]
Gouverneur [illegible]
Middletown State [illegible]
Bellevue Hospital
Broad Street [illegible]
Harlem Hospital
Memorial Hospital
Mount Sinai Hospital
St. Vincent's [illegible]
Willard Parker [illegible]
Physicians' [illegible]
Rochester State [illegible]
Cronse-Irving [illegible]
Masonic Home [illegible]
Utica State [illegible]
Willard State [illegible]
St. Joseph's [illegible]

Always marked with the "Diamond"

Jenkins Valves

1964

VOL. I OCTOBER, 1927 No. 4

THE PSYCHIATRIC QUARTERLY

PUBLICATION OFFICE
Utica State Hospital, Utica, N. Y.
BUSINESS MANAGER
T. E. McGARR
Room 124 Capital, Albany, N. Y.

Annual subscription of Quarterly	$2.00
Single copies	.50
Annual subscription of Supplement	1.00
Single copies	.25

UTICA, N. Y.
STATE HOSPITALS PRESS

DEPARTMENT OF MENTAL HYGIENE

FREDERICK W. PARSONS, M. D., Commissioner
SANGER BROWN, 2d, M. D., Assistant Commissioner

LEWIS M. FARRINGTON,	Secretary
WALTER L. HUTCHINS,	Assistant Secretary
HELEN A. COBB,	Assistant Secretary
PHILIP SMITH, M. D.,	Deputy Medical Inspector
RICHARD H. HUTCHINGS, JR., M. D.,	Deputy Medical Inspector
GEORGE H. KIRBY, M. D.,	Director, Psychiatric Institute
HENRY A. BUNKER, Jr., M. D.,	Asst. Director, Psychiatric Institute
SPENCER L. DAWES, M. D.,	Medical Examiner
AMOS E. BARTON, M. D.,	Deputy Medical Examiner
JAMES L. TOWER, M. D.,	Psychiatrist
Z. FRANCIS SHAFER,	Auditor
FRANK O. BAUER	Assistant Auditor
DUDLEY B. MATTICE	Assistant Auditor
TIMOTHY E. McGARR,	Treasurer
HORATIO M. POLLOCK, Ph. D.,	Director, Statistical Bureau
Mrs. ELEANOR CLARKE SLAGLE,	Director of Occupational Therapy
JAMES E. SIMPSON,	Supervisor of Physical Instruction
JOHN F. O'BRIEN,	Counsel
CHARLES B. DIX, M. E.,	Inspector of Buildings and Engineering
JOHN T. NORTON,	Inspector of Dairy Products
CORONAL THOMAS,	Chief Field Agent

SUPERINTENDENTS OF STATE HOSPITALS AND INSTITUTIONS

STATE HOSPITALS

BINGHAMTON,	WILLIAM C. GARVIN, M. D.
BROOKLYN,	G. W. MILLS, M. D.
BUFFALO,	*CHRISTOPHER FLETCHER, M. D.
CENTRAL ISLIP,	GEORGE A. SMITH, M. D.
GOWANDA,	EARLE V. GRAY, M. D.
HARLEM VALLEY,	JOHN R. ROSS, M. D.
HUDSON RIVER,	CLARENCE O. CHENEY, M. D
KINGS PARK,	WILLIAM J. TIFFANY, M. D.
MANHATTAN,	C. FLOYD HAVILAND, M. D.
MATTEAWAN	*JOSEPH W. MOORE, M. D.
MIDDLETOWN,	ROBERT WOODMAN, M. D.
ROCHESTER,	JOHN L. VAN DE MARK, M. D.
ST. LAWRENCE,	PAUL G. TADDIKEN, M. D.
UTICA,	RICHARD H. HUTCHINGS, M. D.
WILLARD,	ROBERT M. ELLIOTT, M. D.

STATE INSTITUTIONS

CRAIG COLONY,	WILLIAM T. SHANAHAN, M. D.
LETCHWORTH VILLAGE,	CHARLES S. LITTLE, M. D.
NEWARK STATE SCHOOL,	ETHAN A. NEVIN, M. D.
ROME STATE SCHOOL,	CHARLES BERNSTEIN, M. D.
SYRACUSE STATE SCHOOL	O. H. COBB, M. D.

*Acting Superintendent.

TABLE OF CONTENTS

ADVANTAGES OF COLONY CARE OF MENTAL DEFECTIVES*

BY CHARLES BERNSTEIN, M. D.,
SUPERINTENDENT OF ROME STATE SCHOOL

There are several outstanding advantages of colony care for mental defectives, namely:

1. Availability of houses in towns for females and farm houses for males and these pieces of property under rental, may be taken on short notice and made available within a few weeks, thus quickly meeting the need for increased numbers without overcrowding institutions.

2. Humanitarian consideration of the individual patient. It is our experience that inmates are always glad to live at colony homes where they are cared for in small numbers and thus, individual attention may be given the patient and his individual likings in food, lodging, associations, etc., may be more carefully considered.

3. A large variety of environmental conditions may be created in these small groups fitting the individual to the environment which seems to suit him best.

4. Much larger opportunity may be given the individual to contribute toward his own care and support, such as, assisting with general house work, preparing food, doing the laundry work, working on the land and producing food supplies, etc.

5. Possibility of giving all inmates home life, surroundings and conditions more nearly like those of their natural home life previous to institutional care even to the extent of having the colony located in a community where he may have contact with individual friends or relatives and thus, if desirable, to have an opportunity to carry on work with those with whom the individual previously associated.

6. The establishment of a simple protected environment in which the individual can live without great stress or extreme effort to meet social and economic demands.

7. Economic or cost values.

A fair basis for rental values is 10 per cent of the tax value of the property which will about equal a rental basis as follows:

Twenty-five dollars per bed capacity per year for the use of the

* Address at Quarterly Conference at Rome State School, September 20, 1927.

house and if there are reasonable out-buildings and barns on the place $2 to $3 per acre for the land for a 100-acre farm. This will make a rental value of $500 for the house which will accommodate 20 inmates and from $200 to $300 for the land or a total of $700 to $800 per year rental for such a farm.

Under these conditions the owner will pay taxes and insurance and will usually allow the institution about $200 per year of rental money for repairs to property. If this $200 is used to buy material, and labor done by institution inmates and skilled help such property may be greatly improved in the course of two or three years. Where such improvement takes place, of course, the State, town and county derive benefit through increased taxation based on increased valuation.

Under these conditions of rental a 200-acre farm would have rental value of $500 to $600 for the house as usually the larger farm will have the larger house and room may be found for 24 inmates and about $400 to $500 for the land, making rental from $1,000 to $1,100 per year for a 200-acre farm. Usually the larger farms will have better buildings thereon, especially better out-buildings for cattle, storage of crops, etc.

Under these conditions the costs of maintenance per year are from two-thirds to three-quarters of what it actually costs to maintain a like number of inmates at the institution, this because at the colony the inmates do much of their own washing, do their own cooking, chamber work, house work, etc., which reduces considerably payroll costs per capita.

Also the overhead costs per capita under rental is less than the investment charge for buildings, were they built for a like number of patients at present prices.

The two main considerations would be that of immediate availability of more bed space at an economical cost and the humanitarian treatment of the individual from the standpoint of his associations, daily life, etc., and the relieving of the individual of the necessity of becoming institutionalized through a long-term residence in a large congregate institution where later the habits of life thus formed tend to render the individual ever thereafter lonesome and discontented when removed from such institutional environment.

In planning for the care and training of the higher grade feeble-

minded or mentally defective from year to year during the past 30 years, and basing our deductions and plans on previous experience as an indication for future needs, we very early—some 20 years ago—became convinced that several of our practices as well as objectives were faulty, and a revision or complete change of procedure was necessary to render practical and successful the care and training of these cases.

All having to do with the work were gradually assuming the viewpoint or attitude of institutional custody for life for all of this class of human beings, and as the large and ever-increasing total number to be cared for under this extremely costly system of care accumulated in our institutions, and the span of life of the individual lengthened with better physical care and hygienic surroundings, it became very evident that other means or procedures were necessary and that some other form of care or plan of training should be devised to meet the needs of this special group.

During this time many patients were idle or occupied at work that had little economic value and many of them thus further deteriorated or degenerated and became more dependent, burdensome and costly to care for.

We found that the general effect of institution life and training is to institutionalize the inmates; that after several years of continuous existence in an institution—even the best—a large majority of individuals thus cared for require correction of many habits of life contracted through association with large numbers and constant personal supervision, resulting in their losing or never gaining self-reliance or initiative. It was therefore, decided that the gulf between the institution and the outside home, with a more or less independent existence outside the institution, must be bridged. To accomplish this end we adopted the rural farm colony as a first move from the school to open farm life, and then later parole on trial to a reliable farmer—if possible one whose acquaintanceship was gained by the boy through assisting the farmer by the day or week while living and receiving his training at the farm colony.

The plan is: When these boys reach 12 or 14 years of age and show no special mechanical ability, lag behind three or more years in grade school, and are able to make no further progress in formal school work, they go to live in groups of 16 to 24 with a farmer and his wife. When they have reached 16 years of age and have proved

trusty and reliable they are allowed to go on parole with an outside farmer to assist as farm hand, as well as assist the woman in the house—all of which the boys have learned to do during their residence and training at the farm colony.

On September 1, 1927, we had boys and girls in colonies and on parole as follows:

	Males	Females	Total
Population of institution	2,006	1,152	3,158
In colonies	499	357	856
At home on parole	220	142	362
At work on parole	114	61	175

The following table gives statistics relative to farm colonies opreated during the year 1926, and proves the wisdom of such colonies from the strictly financial point of view.

STATISTICS OF COLONIES FOR BOYS, CONDUCTED BY ROME STATE SCHOOL, 1926

Colony	Acres	Beds	Earnings	Rent	Salaries	Supplies	Total cost
Ayres	25	16	$1,721.95	$300.00	$1,419.00	$2,393.63	$4,112.63
Beck	78	20	5,068.92	900.00	1,296.00	2,518.93	4,714.93
Brown	195	24	3,333.13	1,000.00	1,419.00	3,478.84	5,897.84
Brush	187	20	5,852.60	owned by state	1,419.00	2,771.29	4,190.29
Dewey	90	20	3,453.18	600.00	1,419.00	3,074.28	5,093.28
Green	100	20	3,474.81	800.00	1,340.00	2,925.68	5,065.68
Greenfield	80	16	1,991.09	600.00	1,276.00	3,105.15	4,981.15
Hamil	40	24	764.31	800.00	612.00	3,157.43	4,569.43
Howe	80	20	3,818.78	800.00	1,419.00	3,317.96	5,536.96
Kline	240	24	3,720.90	1,100.00	1,419.00	3,791.08	6,310.08
Kossuth	..	32	12,408.87	1,020.00	2,530.62	9,073.00	12,623.62
Lawrence	650	36	2,461.25	1,100.00	1,419.00	5,314.11	7,833.11
Maurer	125	16	3,922.36	800.00	1,407.00	2,846.05	5,053.05
Rathbun	240	24	3,634.51	1,200.00	1,140.00	3,340.25	5,680.25
Rogers	140	16	3,389.75	600.00	1,419.00	2,631.87	4,650.87
Smith	123	24	3,995.32	1,000.00	1,407.00	2,960.17	5,367.17
Spencer	95	24	808.03	600.00	1,411.00	3,059.72	5,070.72
Stook	273	20	10,350.36	1,200.00	1,419.00	3,056.02	5,675.02
Talcott	200	24	10,265.75	1,000.00	1,419.00	3,264.56	5,683.56
Verona	140	20	2,775.46	1,000.00	1,419.00	3,387.56	5,806.56
Valatie	395	60	16,333.92	donated	4,602.00	22,037.60	26,639.60
			$103,545.25	$16,420.00	$32,630.62	$91,505.18	$140,555.80

The report for 1926 shows that over 40 per cent of our total population of 3,100 is provided for outside of the central institution, at a saving of over $2,500,000 in cost of housing and bed capacity. In addition, the State is saved a large part of the annual maintenance cost of $250 to $300 per inmate for these 1,400 patients, totaling over $300,000 annual saving. But of greater value than all this money saving is the conservation of human beings and human resources in a most humanitarian manner, which reacts not only to the advantage of the individual but also to the benefit of the State.

Financial Statement of Girls' Colonies for the Year, 1926

Colony	Amt. on hand July 1, 1923	Earned during year	Expended during year: Furniture & Equipment Cash	Furniture & Equipment State Contributed	Operating expenses Cash	Operating expenses State contributed	Cash to inmates	Clothing Cash	Clothing State contributed	Total costs	Cash on hand July 1, 1924
Rome Group	$1,256	$9,200	$333	$263	$7,227	$4,021	$1,523	$3,049	$445	$16,861	$1,230
Syracuse	2,119	8,783	200		5,786	41	1,273	1,384		8,684	1,460
East Aurora	195	11,151	295	38	9,333	856	1,903	978	7	13,500	548
Hamilton	25	3,784	253	59	3,739	1,236	768	861	287	7,203	91
Frankfort	75	2,292	1,002	561	5,032	3,229	440	220	436	10,920	195
Gloversville	745	5,583	162	210	4,050	828	743	136	5	6,134	1,539
Oris. Falls	563	5,782	1,879	379	4,355	2,032	712	631	80	10,088	101
Rich. Springs	1,578	12,753	946	1	6,609	1,144	1,561	1,349		11,010	1,064
Clayville	2,266	17,968	2,471	159	6,527	2,341	2,770	1,452	72	15,792	1,886
	$8,822	$77,296	$7,541	$1,670	$52,658	$15,728	$11,783	$10,060	$1,332	$100,772	$8,114

There are at least two very good arguments in support of colony care for those who are subject to or in need of assistance during the period of their incapacity or enforced limited freedom and action, namely:

First: The great need for making the limited funds available reach the largest number possible.

Second: The advantages of rendering the enforced restriction of freedom and the economic and social limitations as humane and as little humiliating as possible.

We all realize that with the limited funds provided or attainable, as well as the limited housing accommodations available for the care of these classes under ordinary methods of procedure in care and treatment, especially where the individuals require so long a period of continuous custodial supervision, it is impossible for us effectually to provide for all of our cases. Under the colony system, however, where the earning capacity of the patients is early elicited and thus the greater part of the expense met from their earnings and thrift, much larger numbers may be provided for.

Numerous large and medium-sized houses and farms and farm buildings well suited to the purpose are readily available, either through rental or purchase, as the needs and funds may warrant; and even though the initial funds are small, rental is always possible.

Here, to, because of the small and various units dealt with, a large variety of occupations best fitting the various local groups and communities can be instituted, which may be easily and readily

varied to meet changing conditions of individual occupants as well as local demand.

The humane as well as the non-humiliating aspect of the work, especially as applied to the mental hygiene and eugenic program, should not be lost sight of; for surely it is as much our duty to be considerate of these individuals and their interests as it is the duty of society to limit the sphere of their activities. Thus, the groups should be kept small and their interests encouraged and supported. In this way, they are prepared for parole and discharge. They are not browbeaten, forlorn and discouraged individuals, but hopeful, self-respecting, independent human beings.

It is our experience that a unit of from 16 to 24 girls or boys living in a colony under the supervision of a man and wife, or girls under a woman and an assistant, can easily earn sufficient to support the unit, and in prosperous times have a little surplus for individual savings. In this way self-respect is engendered in the individual, rather than dependency, humiliation and discouragement. Rather than handing out alms we are supervising self-earned support and instructing our patients not only in hygiene and animal inhibition, but also in habits of industry and thrift and honorable self-support —the sheet anchors of moral prophylaxis.

A recent review of the work carried on at the great colony of Gheel, Belgium, carried the very significant statement that "daily experiences at the colony demonstrate that many cases who are dangerous in the home life of their own family are absolutely calm and orderly at the colony."

Here is proved again, if such proof is necessary, that what many of our social misfits and mentally alienated subjects need is not lockups and custodial institutions and prisons, or even hospitals— except the latter temporarily for purposes of classification and treatment when acutely ill—but rather changes of environment. They need, not the restraining influence of brick walls and iron enclosures and guards, but rather the sustaining, diverting and comforting influence of a modest and sanitary home presided over by a house mother with feeling and insight bred of experience. Verily, social hygiene and mental hygiene are not only closely interrelated, but also interwoven.

We are more firmly than ever of the opinion that from one-third to one-half of all the feeble-minded and mental defectives that must

receive State care and training can well be cared for under a reasonable system of colony and parole care and supervision, and this, too, at a great saving in expense to the State and a correspondingly great benefit to the individual as well as to the community through furnishing to the community labor which would otherwise be unavailable. This work was begun for boys in 1906, and for girls in 1914.

As we see the situation in an institution of 1,000 or more inmates, not only are many of the inmates sitting around in a most inactive and listless state and gradually deteriorating since their services are not needed in the daily routine work, but there is also a very considerable number who are greatly disturbed and troublesome. In the case of the latter a large amount of energy is going to waste or worse, even to destruction, not only of physical property but also of bodies and minds, which energy might well be diverted and rendered useful along lines where common as well as expert labor is in great demand, and whereby the individual would be correspondingly benefited.

As a result of our experience of 21 years with colony and parole work with boys and 13 years with girls, we are convinced that where such boys and girls can render themselves self-supporting, even to the extent of paying for their own supervision; and where girls can earn, as many of these girls do, from $14 to $21 per week in mills, and at domestic work from $3.50 to $7.00 per week and maintenance, and boys from $15 to $25 per month and maintenance on farms and $9 to $18 per week in stores, mills and gardening, society has no moral right to deprive either the individual or the community of such opportunity and service.

We are also convinced that no institution for 1,000 or more of this class of wards can longer continue to exist and do its full duty to the individual patient as well as to the State and the public which does not institute a system of parole and discharge as applied to favorable cases. No such system can be made as widely applicable and successful as it can and should be without the aid of colony supervision during the rehabilitation period for those patients who have no suitable home or relatives to befriend and supervise them —at least until they are trained, and accustomed to and established in their own environment.

ARE COLONIES PRACTICABLE IN THE TREATMENT OF THE INSANE?*

BY CLARENCE O. CHENEY, M. D.,

SUPERINTENDENT, HUDSON RIVER STATE HOSPITAL, POUGHKEEPSIE, N. Y.

If by "colonies" for the insane, we mean buildings or groups of buildings on the hospital property, segregated at a greater or less distance from the main congregate building of the parent institution, and if we define "practicable" as referring to something possible to put in use, the question in the title of this paper is answered immediately, when we point out that such colonies for the insane have been in use in this country for over forty years; it would appear from this definition or viewpoint, therefore, that there was no need for further discussion of the question.

If, on the other hand, we imply in the word practicable a meaning of usefulness, reasonableness, propriety, or desirability, we bring up with the title of this discussion, questions that may be answered, and have been answered, differently, according to one's experience and perhaps prejudice; such questions would seem to merit consideration and discussion, and it is these which we wish to bring up for possible elucidation.

Those administrators who first advocated or have continued to advocate colony care, with its segregation or classification of small groups of patients in detached buildings, have opposed the conceptions of those who saw in the congregate, Kirkbride, corridor type of building, with its one thousand or two thousand patients the most proper or only type of construction to care for the insane.

Ostrander of Kalamazoo, writing in 1916 on colony care, describes the colony connected with that hospital, which he says is accredited as the first attempt in America to colonize chronic insane on farms. He points out that "In 1885 a tract of 250 acres of productive land, situated about three miles north of the parent institution, was purchased for a dairy farm and a cottage was erected to accommodate about 45 men patients, to be employed in looking after the herd in raising general farm products. This addition to the institution was known as the Brook Farm.

"This venture not only 'fully met the immediate expectation of the officers and trustees by furnishing milk to the institution and

* Read at Quarterly Conference at Rome State School, September 20, 1927.

occupation for the patients,' but it also 'suggested how other supplies and increased accommodations might be provided at a much reduced cost to the institution and to the state.'

"In 1885 the trustees considered the further extension of the institution by what they were pleased to term the colony system. The original plan contemplated the acquisition of a large tract of land in some farming community near the institution, the erection of suitable cottages, each with a capacity not exceeding 30 patients, a residence for the physician in charge, a chapel and an amusement hall, and the necessary farm out-buildings."[1]

Plans for the development of the colony did not materialize entirely as was desired, because of lack of sufficient appropriations, but in 1916 the colony is described as having one cottage for 72 men patients, three cottages for women patients, a physician's residence, a central heating plant, a general dining room, easily converted into a dance and amusement hall; a laundry and sewing room, and a home for nurses.

Ostrander stated that from personal experience over a period of nine or ten years he had been convinced that such colony care was the best plan yet devised for the treatment and care of at least 60 per cent of the insane of the institution. He pointed out that 17 states in 1912 had farm colonies in operation in connection with public institutions. Undoubtedly in the past ten years the number of such colonies in United States has materially increased.

In our own state there have been for years detached colonies in operation at Binghamton, Rochester, Utica and Hudson River. We may speak briefly from personal experience of those of the last two hospitals. They present a variety of conditions and problems from which one may gain some idea of their usefulness—their advantages and disadvantages.

At Utica the farm colony still known as Graycroft, about a mile from the main building, was opened in 1897 on leased ground, which has since been purchased. This colony is a farm house, in which from 20 to 40 workers are housed. For a period of years, up to the time Marcy was opened, about ten women patients were also housed there, assisting with the house work. The men patients

1. The Colony System. Institutional Care of the Insane; Vol. I; Johns Hopkins Press, 1916.

worked on the farm, which included a dairy, from which much of the hospital milk was provided. The house itself was not well adapted for patient care, and has been condemned as a fire hazard. But it seemed that, nevertheless, there were many advantages. The patients were in surroundings which were more nearly like those they had been used to and more normal than the main institution surroundings. There were no bars on the windows; all the men had parole of the grounds, with a consequent freedom from restriction, and in the evenings a comfortable sitting room provided a place in which to read or play games. A number of the patients adjusted themselves so well to the farm work that they were discharged and placed on the payroll as drivers or workers in the dairy. Because of the location of the farm colony, patients could easily be visited, or brought in for visits, or in case of indicating mental symptoms or acute illness, brought back to the hospital for care. The patients' general health was good and those who were sent to Graycroft could be expected to improve in their physical health.

Before the development of what is now the Marcy Division of the Utica State Hospital, two farm houses known as Overlea and Woodside were occupied by about 50 patients as farm workers. These houses were some eight miles from the Utica Hospital and were, therefore, before Marcy was built, isolated so that it was more difficult to give them the medical supervision desirable. They did not afford the opportunities to the patients of amusement and church attendance that the patients in the main hospital had. Here likewise, however, the patients appeared generally contented, with freedom of the grounds and their home-like surroundings; each house had its own kitchen and dining room. One house was supervised by the head farmer, and the other by a charge attendant, their wives doing the cooking. Here, likewise, a number of patients became qualified to be placed on the payroll as farm workers and remained as steady, comparatively reliable, employees. The houses of frame construction were outstanding fire hazards, and it is interesting to note, perhaps, that a patient in one of them, on reading of the fire at Ward's Island, where he had been at one time a patient on one of the wards that had burned there, attempted

to set fire to the farm cottage during the night. It gave us cause for thought on what would have been the loss of life if he had not been detected and the fire put out before it caused damage.

A great step in advance was taken by the construction and operation of the present modern, fireproof colony building at Marcy, built for 125 patients. Although by no means inexpensive to construct, it affords safe, sanitary, comfortable housing for these patients, most of whom work on the farm, which, with its dairy, now produces all of the Marcy milk, and has raised as much as 12,000 bushels of potatoes in the season, more than enough to supply the whole Utica hospital. The less able-bodied patients there occupy themselves with the care of the house, the grounds around, or in occupational therapy class work, which includes bag ravelling and rug and basket making. The close proximity now to the other Marcy buildings offers a distinct advantage of allowing the patients to attend church and amusements in the improvised assembly hall, of seeing baseball games, and of having close medical supervision. It is difficult to conceive of how conditions in a farm colony, both for the patients and for the hospital, could be more ideal.

The larger number of patients cared for at the Marcy Colony have been of the chronic or continued treatment type, usually having been transferred from the down-state hospitals. The colony would seem to offer, however, a valuable opportunity for rehabilitation of recoverable patients, who could respond to, and be helped by, the separation from the larger, more confining wards, and by the graded exercise and the open-air life which is available there.

In contrast to the farm colony at Marcy stands the Hudson River colony, known as Broadacres. Here, 25 miles from the main hospital, on a good farm of 850 acres, formerly known as Camp Whitman, and after the war turned over to the hospital, there was about a year ago, an old farm house, with by no means new barns, no sewage disposal, and with water supplied from a shallow well. Here 12 or 14 patients came from the main hospital to work on the farm in summer. Conditions were quite primitive. Concerned as we were with the fire hazard, with money appropriated for repairs, electric lighting was installed in place of lamps, but soon afterward a fire broke through the old sand mortar in the chimney and destroyed the house. The repairs then developed a new one-story comfortable cottage for 12 to 16 patients, with proper sanitation,

heating, and water supply. It is difficult to convince one's self however, notwithstanding the improvements, that the conditions under which this farm colony is operated, work for the best interests of the patients, or of the hospital. The distance of 25 miles from the main hospital is one of the outstanding disadvantages. Transportation of supplies is expensive and inconvenient. The colony cannot be kept in close contact with the other departments of the hospital, as would be best; medical supervision is not easy. The patients do not have an opportunity of having the benefit of amusements and recreation, available to patients in the main hospital. Patients have to be selected for their reliability and stability as they cannot be easily returned to the hospital, and the more acute patients who might benefit by the farm life, are not apt to be selected; appreciative, convalescent patients would feel the isolation. The farm has possibilities for development, especially as a dairy farm. It is believed that for proper development there should be an adequate patients' building, or buildings, quarters for the necessary farm and ward personnel, officers' quarters, and facilities for recreation of patients.

Hudson River does have, however, a colony group, of which it is, we believe, justly proud, as a unique development of colony care. This is the so-called Cottage group, a series of eight brick cottages, accommodating from 54 to 72 patients each, on the main hospital grounds about two and one-half miles from the main buildings.

It may be of some interest to record here the thought that apparently foreshadowed the development of this colony group. In the report of the Board of Managers of the Hudson River State Hospital for the year ending September 30, 1890, one finds decried the disadvantages to the patients of the large wards in the large main building. One may quote the following: "It is believed that some of the evils complained of in the present system would disappear or be notably lessened, if quiet and harmless patients were cared for under conditions more nearly allied to family life, having at the same time the constant oversight of the skilled physician.

"It is believed that a large majority of the 3,400 insane belonging to the Hudson River counties might be provided for in small buildings grouped in hamlet fashion, each group to accommodate 250 to 300 patients; each hamlet to be in the center of a farm of several hundred acres, and to have its farm buildings and stock; also a

building in which light mechanical work would furnish occupation in winter; and a small cottage hospital for such as needed its care; and in the center of the group a residence for the physicians having the immediate care of the patients. The cottages would be homely perhaps, but home-like and comfortable in their arrangements, and so disposed about the grounds and among the trees as to give a pleasing and picturesque affect.

"*Occupation* would be the keynote or motive of the hamlet life, and this in the open air and amid familiar rural scenes. The products of the soil would go far towards the maintenance of the establishment, and in time yield a surplus to be sold at a profit in the markets of New York city. Such agricultural colonies, established from time to time as necessity demanded, and scattered about among the beautiful hills and valleys lying just east of our present hospital, and all being under one central control and management, would furnish economical and adequate provision for housing and supporting the natural increase of the insane population which is now adding annually more and more to the burden of taxation."

This desired plan outlined by the Managers did not materialize, of course, in its entirety, but that the thought did bear some fruit is indicated in their report for the fiscal year ending September 30, 1892, where one meets a statement that "the eight cottages to accommodate 288 patients are nearing completion and will soon be ready for occupancy." It was planned that they would accommodate 36 patients each. They were of two-story brick construction, each with its own kitchen and dining room. The total cost of construction and furnishing of these cottages was reported at that time as $156,932. There was no sewerage system, privies only being available; water supply from wells was at first attempted; subsequently a creek near by was dammed and a pumping station installed for water supply which, in turn, was found to be inadequate and unsatisfactory so that the, cottages were eventually connected with the main water supply from Hudson River at material expense. A sewerage system connected with the general system was later installed. That the cottages were not so constructed as to well stand long use, is indicated by the fact that in the report of the superintendent in 1896 and in subsequent years one finds requests for repairs to the floors and ceilings, kitchen and dining rooms of the cottages, to put them in proper repair. The records

of the hospital show that since their initial construction, not less than $56,900 have been spent in repair and renovation of these cottages. By the expenditure of money made available for the current year, it is hoped that all of the eight cottages will have been thoroughly renovated and placed in repair that will last for many years.

At the present time a variety of patients is cared for in these cottages. Five are for women; three of these are for the quiet, appreciative essentially chronic cases, one is for habit training, where the results have been very satisfactory, and one is for female epileptics. One of the cottages is for male epileptics, one for the male tuberculous patients, and the last is for male farm workers.

Shortly after the group was established the superintendent pointed out that it would be desirable, because of the distance from the main buildings, to have storage facilities, sewing room, recreation center and quarters for the physician in charge of the group. The latter were provided, so that the two physicians detailed to the service reside in one of the cottages and are, therefore, in close contact with the cottage activities. A small Catholic chapel has been constructed, and is used regularly. No recreation center, however has ever been provided, and the patients have to walk or to be transported for their regular diversion to the central assembly hall. All of the patients cannot be given this opportunity. It would be a distinct advantage to have a recreation center for the group, as well as church facilities for the Protestant patients. With the present automobile transportation, supplies are more easily carried daily, as they have to be, to the cottages, than was formerly the case.

It is a matter of common knowledge in the hospital that food preparation and service in these cottages is more satisfactory for the patients than anywhere else in the hospital. There is no cause for the objection made in the larger buildings that the food is cold or not palatable. The epileptic men and women can have their diet carefully supervisd in these cottages. It was a matter of remark some time ago when the epileptic men were transferred back to one of the larger patient buildings that they in general lost considerably in weight which they regained when they were returned to the cottage. Frequently when patients are first transferred from the main building to the cottages, they object that they are far distant from the main activities of the hospital or from transportation

facilities for their visitors. It is usual, however, that in a short time both the patients and the visitors appreciate the advantages of the cottage care and return to the main building is not then asked for. At the present time there are 537 patients in the Cottage group. It is felt that, as a whole, this makes a very desirable arrangement for caring for a diversified class of patients, and has many advantages over care in the larger wards.

In conclusion, then, of a consideration of this type of care for patients in the hospital, we seem to be justified in asserting that colony care, either for farm workers, or for other types of patients is advantageous, desirable, and helpful. There are certain things that we feel should be emphasized in arranging for colony care. It is believed that the possible benefit to the patients should always be kept uppermost in mind, and that the labor of the patients and the products of this labor should be held as of secondary importance. As long as we are maintaining hospitals for the care and treatment of the insane, it would seem that this care and treatment should be emphasized, rather than the use of the labor of the patients to reduce the per capita cost. Farm colonies, as we see it, should be placed in convenient proximity to the main divisions of the hospital, so that the patients may have careful medical supervision, and so that transfers from and to the cottages and main buildings could be easily carried out. The proximity to the main hospital will afford opportunities for attending church and amusements that are not available if the colony is too far removed. The more nearly the colonies approach the well-organized home, the better it will be for the patients. Activities in housekeeping and in the care of gardens will obviously tend to restore a patient to more normal attitude. Experience would seem to show that it is financially sound to construct farm colony buildings in a substantial manner, so that they will last a long period of years, rather than to depend upon the more flimsy frame construction, with its repeated demands for repair. Inasmuch as policy seems to have determined that the insane should be cared for in fire-resisting buildings for the protection of life, it would not seem desirable to advocate anything less for colony construction. The details of a plan for colony development would obviously have to be worked out according to the conditions prevailing at each individual hospital, in respect to the size of the

grounds, the acreage in farm land, water supply, sewage disposal and transportation facilities.

We have so far kept to our definition of a colony as a building or group of buildings on the hospital grounds. But personal thought, discussion with others, contact with Dr. Bernstein, and a knowledge, through his courtesy, of the actual workings of his colonies, has led us to consider the practicability of the establishment for the insane of houses or colonies apart from the hospitals and in the communities, but maintained by the State, for the benefit of parole patients, as an aid in reestablishing the latter in the communities to become self-supporting members of society. No experience with such a practice has been accumulated in this State. To determine whether other states had had such experience, a letter was written by us to the superintendent of a representative hospital for the insane in every state in the Union, asking whether such parole patient colonies had been established, and if so, what the experience was with them. The only reply of 27 we have received indicating that such experience has been had with a colony for parole patients came from Dr. May, the superintendent of the Boston State Hospital. He reports that what he calls an occupational therapy center for mental patients was established under the direction of his head social worker during the summer of 1922, and made possible by private contributions. During one year 15 different patients had been given convalescent care, their residence at the center extending from ten days in some cases to over a year in others. "With two exceptions, these patients have all shown marked improvement, some of them having recovered sufficiently to take their places in the community and live normal, helpful lives. Several of them have been enabled to return to their homes and, while not entirely recovered, are doing well, and improving continually. The atmosphere at the center is that of a large family, each patient there sharing in the home duties. An occupational instructor is employed at the center one day each week, and the work is all graded according to the abilities of the individual patients, ranging from the simplest sewing to the highest type of skilled handiwork. The therapeutic aspect of the work is not lost sight of in the effort to produce articles of real commercial value and the attempt to render the center partly self-supporting. During 1923 nearly $800 worth of the work of patients at the center has been sold, this representing the amount paid to the patients

after deducting the cost of the materials. There is a very real need for just the sort of care and occupational interest that can be provided for patients in centers of the type described, but the hospital can only make a beginning at the present time. Repeatedly, cases are referred to the Social Service Department for readjustment in the community, and many times the homes to which these patients must necessarily return are such as to render improvement or recovery impossible. In cases of this kind the convalescent center, with its help to readjustment through occupation, is of great value. It is hoped that the center at Hopkinton may demonstrate its benefit to patients to such an extent that with greater faciliies in the future other centers of this type may be established and the field covered may thus be considerably broadened."[2]

There is suggested at this time for consideration, the possibility of the State hospitals in this State establishing in their communities, preferably in cities, houses to be rented, furnished and maintained by the State, and to be supervised by hospital employees, into which patients may come from the hospitals. It is felt that in each hospital there may be few, if not many, patients who could establish themselves as wage earners in domestic service, or in shop or mill work, as Dr. Bernstein's patients have done, if they had a domicile where they could be comfortably housed, without the burden of responsibility of providing such a place for themselves. In such a situation it is quite conceivable to us that an appreciable number of patients would get along better outside than they would if they were left to themselves, and even better than if they tried to return to the family situation, which not infrequently has itself brought about mental conflict and disorder. It is felt that the communities would have to become educated to such a provision. Dr. Bernstein has told you, or can tell you, that when he first established his parole community houses in the various towns, there was a feeling that there would be a certain objection to them, and people at first looked askance at them, but as the town people came to realize the service that Dr. Bernstein's patients could give them, these communities became very appreciative and much interested in them. It is felt that there is no particular reason why the same might not occur in connection with state hospital parole homes.

2. Public Document No. 84, Commonwealth of Massachusetts, p. 21.

It is believed that there are not a few private families in the communities near the hospitals, who have a distinct need for domestic service, which is impossible for those of moderate means to obtain at the present time. It would seem that patients who have been well trained in the hospitals in dining room, kitchen or other domestic work, might, when they were in a comfortable condition, even if not recovered, adjust themselves to outside domestic service, if they had a certain amount of understanding supervision in the hospital home. A patient recently evidenced her own thought along this line when she asked one of the physicians why it was that the hospital did not have some place to which patients could go and live and help support themselves when they could not go comfortably to their own families. Not infrequently we have instances of patients who are physically and mentally capable of doing some domestic or clerical, or other helpful work, outside the hospital, but who have nobody to assume responsibility for their care. And at the same time, private families unused to the insane are loath to take such persons into their homes to live with them. A home for such parole patients would solve this problem. It is believed, too, that patients who might be well enough to leave the hospital under such circumstances, would adjust themselves much better with persons tending to be of their own kind and living together in one house, than they would if they had to adjust themselves immediately to a presumably normal home life with strangers. The details of the financial and other arrangements could be worked out, it is believed, after the policy was once established. It is suggested, however, that patients who were wage earners might be asked to pay the hospital the reimbursing rate for their care, and that they be allowed to place in the hospital account their other earnings, to be drawn upon after the order of the superintendent. The hospital in this way would save materially, particularly in the purchase of clothes and luxuries that the patients might want. When it appeared that the patient was recovered and could be discharged, it would seem that the money earned should be turned over to the patient. We can see certain objections to having money earned by the patients turned into a general account to support a colony home, with this money being used by the hospital or the State to establish or to help maintain other colonies. Such a principle, we believe, is hardly to be advocated for our patients, as it

seems to smack of contract labor. It would appear, however, that there would be no necessity for such an arrangement, if the State undertook to establish and maintain the parole homes. Dr. Bernstein has told you of his having 900 patients outside of his hospital. It is obvious what the difficulties would be in the hospital if these patients had not been paroled. The cost to the State of housing them in the hospital can easily be calculated to large amounts. With the overcrowding in the State hospitals, and the large cost in providing new beds it would seem that the State might eventually be undertaking a sound, economic policy, if it set out to establish the parole homes that we have suggested. Obviously this is a step in an entirely different direction than we have been used to, but we feel that it is worth consideration. I have a report from Dr. C. M. Hincks,[3] of the Canadian National Committee for Mental Hygiene, of his visit to Dr. Kolb, at Erlangen, Germany. Dr. Kolb is said to have had during the last few years since the war 3,000 patients under his direct medical observation in the community. He had hospital accommodations for only 800 and made the statement that if he had not reached the saturation point in community placement, he would have paroled 300 additional cases. It is of particular interest at this time, we feel, to point out that Dr. Kolb stated that he began the experiment with fear and trembling because he was afraid of homicides, suicides and innumerable difficulties. His fears were found to be unjustified, however, and he has satisfied himself that there is no comparison from every point of view—therapeutic, economic, and social—between institution treatment and community care. Dr. Kolb took the precaution of placing the best members of his staff in the work of community supervision. These physicians, themselves, select homes, make visits twice a week and are assisted by social workers in making more frequent contacts.

This experience is reported to indicate that fear and trembling, and a prospect of innumerable difficulties in establishing a new system of care for the insane are not necessarily borne out after the system has been instituted.

We leave the question at this time for your consideration and possible discussion.

3. Personal communication.

DENTAL DEFORMITIES AS FACTORS IN PSYCHOSES

BY R. E. CLOGHER, M. D., D. D. S.,

UTICA STATE HOSPITAL

Dental deformities in themselves are of minor importance, consequently when the dentist is called upon to treat one, his operation is regarded as esthetic rather than curative, and of no particular value other than to improve the appearance of his patient.

That such defects, when left uncorrected can be factors in the production of abnormal mental states has received but scant attention. It is my purpose, therefore, to report five cases showing how uncorrected dental deformities have, in each instance, hindered the proper development of the emotional life of the individual, and also how the adaptations and adjustments of the individual to the environment have been interfered with.

Case 1. A man 28 years old, who had always enjoyed good health, graduated from high school and a business school and had made rapid progress in the business organization with which he was connected. He played several musical instruments and sang fairly well, was a good mixer with both sexes and was popular at parties and social gatherings. He told the following story: "Ever since I was a kid my nick-name was Buck because I had such big front teeth. I never used to mind them much until the past couple of years. I have been going from city to city on different jobs and this is the first place I have been settled at. I have been here two years now and I have made lots of friends, both men and women. I go to dances and all the girls will dance with me but none of them wants to go with me. One girl I was quite stuck on as much as told me she would not go out with me because her girl friends kidded her about my looks. I got so I wouldn't go anywhere on parties and just moped around by myself. I have no pep and I am getting so I hate the job and everything else. Maybe I am too sensitive."

Dental examination showed that his upper anterior teeth were very large, irregularly placed and over-rode the lowers by half an inch. His upper lip did not cover the teeth but did not appear to be shortened. As there were several teeth missing in the back of the mouth it was suggested that he have the front teeth extracted and wear a partial plate. He was told that it would make a great change in his features and might cause comment by those who

knew him. He decided to think it over for a while. A few months later he reported that he was to be transferred to a distant city and wanted the work done just before leaving. The offending teeth were extracted and a partial plate made which was satisfactory. Aside from the fact that it could be told he wore a plate, his features appeared normal. Some months later when he reported, he said: "I am feeling fine and have gotten over the worry about my looks. I am making good progress with a *certain party.*"

Case. 2. A woman 20 years old consulted her dentist to see if her protruding and irregular teeth could be moved. She was told that due to the marked deformity and her age it would be impossible to correct them. Shortly after this she became depressed and worried a great deal about her looks. Finally she consulted her physician who referred her to the writer for examination.

She presented a high narrow arch, crowded and prominent front teeth. The canines were particularly prominent, standing almost at right angles to the molars. She said that she was always very sensitive about her appearance but had trained herself to feel resigned to her fate. She was very frank in saying that she felt her chances of getting married were very small as all the men could do was to kiss her teeth, and none of them seemed anxious to do that. She was shown the photographs (Figures 3 and 4) as examples of what could be done for her by operation and she was very enthusiastic about having it done. Shortly thereafter she went to another city without having the operation performed and has not been seen since so that the outcome is not known.

Case 3. A woman 24 years old had a severe illness which left her suffering great pain in the neck, back and arms. There was atrophy of the muscles in the arms, legs and back and absorption of the alveolus which had produced a marked dental deformity (Figure 1). The dental deformity occurred about six months after the initial illness. Up to this time she had been somewhat depressed because of the constant pain, the long period of illness and the thought that she would never recover, yet she continued to go out and meet people. But when the dental deformity became pronounced she stayed in the house, shunned company and became very depressed. She said: "I became ashamed to have anybody see me and I felt that this was more than I could bear." She came to the hospital as a voluntary patient.

During her stay in the hospital the teeth were extracted and dentures made which restored her former facial appearance. There has been no improvement in her general physical condition and the pains are still present, yet she returned to her work and has recovered from the depression due to the facial deformity. There were other factors in this case but to her the most important was the correction of the dental deformity and she now feels that she can again face the world and even though crippled, earn her living.

Case 4. A woman aged 20. Extract from summary of mental examination is as follows: "There is evidence of defective heredity though it is not clear that this has any direct bearing on the patient's make-up or trouble. Physically, in childhood, she was undernourished and under developed and was not expected to reach adult life. Mentally she was bashful, shy, and suffered a feeling of inferiority which she ascribed to the loss of her father, to poverty, and to being told that her underdeveloped mouth and teeth made her homely. She has one girl chum, a cripple, otherwise has no friends and has a repugnance for the other sex."

The patient came to the hospital because of spells characterized by trembling, cold and numbness, and the fear of death. The first "spell" occurred one year prior to admission following gas anesthesia and she has had three during the year. Diagnosis: Psychoneurosis, hysterical type.

She tells the following story: "My teeth have bothered me all my life and I worried because my teeth were not like other girls'. People would say: 'That kid would be all right if her teeth were right.' They did not develop and they were not in right and they decayed. Maybe that is why I'm so homely. Nobody has ever told me that I was good looking. When I was in school, the girls called me 'granny' and said I looked like a witch, and then I knew I was homely. It made me feel bad. If the girls did not let me play with them I knew it was because of my teeth and once a girl said: 'I would like to have your eyes but not your face.' Other girls said I was homely and could not get a fellow. They made me feel so homely that last year I tried to have them fixed and I have been sick ever since. I had a spell when I came out of the gas. The dentist put a bridge on that stuck out just like my teeth and it hurt all the time."

Examination of the mouth showed a high, narrow, arched palate,

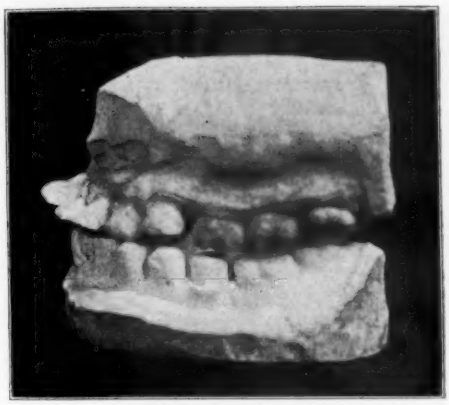


Fig. No. 1—Case No. 3
Dental Defect

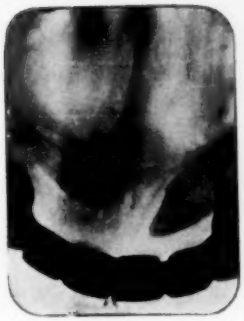


Fig. No. 2—Case No. 4
Showing Bridge Over Unerupted Teeth

Fig. No. 3—Case No. 5
Before

Fig. No. 4—Case No. 5
After

and a six-tooth upper anterior bridge not in articulation with the lower teeth. Pressure on the bridge caused pain in the midline of the mouth. X-ray pictures revealed two unerrupted canines (Figure 2). She was told that the removal of the teeth and the cutting down of the bone in the front of the mouth would allow the wearing of a plate which would improve her looks. She was very anxious to have the operation done.

On September 27 under local anesthesia the anterior plate of bone was removed and the two teeth supporting the bridge as well as the unerrupted teeth were extracted. This made room for the plate and allowed the front teeth to be placed back far enough to be in articulation with the lowers.

A ward note dated October 25 says: "The patient has gained eight pounds since her teeth were extracted. She adjusts more freely, is eating and sleeping quite well and is proud of the fact that she is gaining in weight and has good color. She seems more agreeable than when admitted."

In the latter part of November a plate was made and she was quite pleased with the improvement in her looks, 'though she said she was afraid she would never get over the old feeling about her mouth. This patient has left the hospital and has made a fair adjustment. After a year she says that she has lost much of her self-consciousness about her mouth and no longer fears meeting strangers.

Case 5. The notes taken from the case summary state: "She is 27 years old, much undernourished and underdeveloped, presents a rather stupid appearance and has a high, narrow, arched palate with upper teeth protruding and irregularly set. Mental examination reveals a seclusive type of individual, bashful, shy and masochistic, unable to get away from her home and parents. She has constantly struggled to gain happiness against a feeling of inferiority. The Binet test shows a mental age of 13. She has many somatic ideas and has made threats of suicide. Diagnosis: Dementia præcox."

In speaking of her dental deformity the patient says that all her life she has been aware of her homely looks, and that her mouth and teeth were never like other girls'. She felt that everybody looked at her and made fun of her. The faulty development of her mouth and teeth caused a speech defect which added to her sensitiveness.

The pupils in school mimicked her talk and often made her cry and then laughed at her. Her mother never gave her any sympathy and even acted as though she hated her. As she grew older the feeling of shame due to her facial appearance increased and she became seclusive, hating to meet people. She stayed more and more in the house, worried about what would become of her and many times wished she could die. Often said she would kill herself.

Examination of her mouth showed a very high, narrow palate with the anterior teeth crowded. The lateral incisors were back of the centrals. The temporary canines were present and the first bicuspids were missing. Her lower lip was sore due to pressure of the upper teeth against it. The upper lip did not cover her teeth (Figure 3).

Under local anesthesia the gums were laid back and the central and lateral incisors and the temporary canines were extracted. The anterior plate of bone was removed together with the unerupted canines and first bicuspids on each side and the bone trimmed in order to make room for a denture. A denture was made which greatly improved her appearance (Figure 4). Aside from the improved appearance and her pleasure in this, there has been no change in the patient's condition.

Discussion: Cases 1 and 2 show a depression in persons with dental deformities, who felt that their disfigurement interfered with the success of their love affairs. Up to the age of 20, while they were conscious of the deformity, they reconciled themselves to it. But when their love affairs were unsuccessful they became depressed and blamed their failures on the dental deformity. In Case 1, the correction of the deformity resulted in a rapid and complete recovery. In Case 2 the outcome is unknown but the patient was very much cheered by the thought that she could have her looks improved. In Case 3 a very marked dental deformity, coming on when the patient was already struggling to regain her health, brought on a severe depression. The patient refused to leave the house or to meet company and felt that never again could she face the world. The correction of the deformity brought such an improvement that she has been able to resume her work and has practically lost her self-consciousness as far as her features are concerned.

In Case 4 the patient had poor heredity and environment and

physically was below normal. From early childhood she was jeered and taunted by her companions. Feelings of fear and despair caused her to remain by herself as much as possible and she constantly brooded over her misfortune. She grew up a shy, seclusive, depressed girl with no hope of happiness in life. Her personality and mental make-up have been fashioned to a great extent by the blight of a facial deformity. The improvement in her looks secured by the operation has made her happier and she has made a fair adjustment in life. This case also clearly shows the necessity of doing thorough, and well-planned work, or the results may be harmful. In Case 5 the patient's whole life has been affected by the jeers and taunts of her childhood companions. She became bashful and shy, remained in her home, and developed a hatred of her mother, whom she felt neglected and hated her. On reaching maturity she become a case of dementia præcox.

Disaster and misfortune may act as spurs for some individuals, for in spite of all handicaps they achieve fortune and success. The world knows of a few such cases but the great majority when crippled or deformed are more likely to lose hope, abandon themselves to the charity of their friends and relatives or become inmates of the poor house. Those individuals with unstable makeup may develop psychoses and spend the remainder of their lives in state hospitals.

Practically all dental deformities are preventable and parents should be taught that not only is it necessary that their children's teeth be sound and clean but also that they should be watched for irregularities of position, as the development of the features depends on the position and growth of the teeth. A skilled orthodontist may prevent much unhappiness or the development of a psychosis. Those who have reached adult life can have the deformity corrected by a simple operation.

SOME PRESENT-DAY VIEWPOINTS IN EPILEPSY*

A SYNOPSIS OF THE PROCEEDINGS OF THE GESELLSCHAFT DEUTSCHER NERVENÄRTZE HELD IN DÜSSELDORF IN SEPTEMBER, 1926

BY HENRY A. BUNKER, M. D.,

ASSISTANT DIRECTOR, NEW YORK STATE PSYCHIATRIC INSTITUTE

Spielmeyer deals briefly with the histopathological aspects of epilepsy, asking: What pathological changes do we find associated with epileptic convulsions, to what extent is it possible for research in this direction to elucidate their genesis, and do the results of such investigation throw light on the pathogenesis of the epileptic seizure?

The immediate brain changes which occur after a seizure are both of a generalized and diffuse and of a localized character. The former consist, according to Alzheimer, of acute ganglion cell changes, axis cylinder degeneration, nuclear division in the glia cells, and in especially severe cases a regressive transformation of the glial elements into amoeboid forms. But these changes have thrown no light on the pathogenesis of the seizure because we have not been able to interpret them. The localized changes, on the other hand, are capable of interpretation in this sense.

Spielmeyer has found circumscribed changes in the *cerebellum* and in the *horn of Ammon*. The former he has previously described as consisting of a shrub-like proliferation of the glia cells with numerous mitoses, this occurring in those places where the Purkinje elements have undergone destruction. With the increase, with successive convulsions, of the areas in which the latter have become replaced by glial proliferation, there come into existence areas in which the Purkinje elements are entirely lacking. These patchy and eventually sclerotic areas, which are often overlooked but which are nevertheless extremely frequent in epilepsies of all types, may be traced back to the cumulative tissue loss (Purkinje elements) associated with the seizures. It is Spielmeyer's conjecture that the Ammon's horn sclerosis may be analogous to these circumscribed areas of sclerosis in the cerebellum, and that their origin may possibly be ascribable to similar acute changes. Among 36 cases of status epilepticus he found acute changes in the typical regions of Ammon's horn in six, three of which were cases of idio-

* The first part of this synopsis appeared in the PSYCHIATRIC QUARTERLY for July, 1927.

pathic and three of symptomatic epilepsy. In these cases a process of fresh degeneration was encountered in those parts of Ammon's horn which in Ammon's horn sclerosis show definite tissue loss with gliosis. One can follow the diminution and disappearance of the ganglion cells, and the reaction of the glia in the form of proliferation and inclosure of the degenerating nerve cells.

Associated with epileptic seizures there occur, therefore, in addition to diffuse changes demonstrable with difficulty, localized areas of tissue loss in the cerebellum and in the horn of Ammon. After status lasting some days and after seizures which precede death by a few days, these can be demonstrated in the majority of cases, sometimes only in Ammon's horn or only in the cerebellum, sometimes in both. Spielmeyer, in his material, found changes such as these, associated with convulsions, in 80 per cent of cases of both idiopathic and symptomatic epilepsy.

For the demonstration of the part played by the pathological changes in the pathogenesis of the disease two methods are open: To discover the basis of the site of election of these alterations and to ascertain the manner in which these changes evolve *in loco*. Spielmeyer has already employed the first of these methods, having some time since reported that the areas of tissue loss in Ammon's horn in epilepsy correspond in their regional distribution with the similar areas conditioned by circulatory disturbances, such as those which occur as a result of arteriosclerosis or endarteritis. Hence the conditions with reference to the *local circulation* are the preponderant factor in the involvement of these areas, which, as we have seen, are about always the same in situation; and this is true even when there are certain variations in the latter respect. This follows also, indeed, from the investigations of Uchimura upon the blood supply in the region in question (diminished or inconstant blood supply in the situations above referred to, and an abundant blood supply in the more resistant areas). Thus it is possible to conclude that the site of election of the pathological changes is governed not by physico-chemical considerations, but by vascular and circulatory disturbances.

Regarding the character of the structural changes, the ganglion cell appearances are those of ischemic degeneration. Around the cell shadows glial rods later proliferate, in which lipoid catabolites become stored up and which take part in the removal of the waste

products. In all the phases of degeneration, breaking down and removal of waste products, the lesions which we find associated with epileptic convulsions resemble ordinary ischemic foci. This is true likewise in the cerebellum.

But no demonstrable changes of any kind are found in the blood-vessels as the cause of the ischemia. The circulatory disturbance must, therefore, be a functional one, and it must consist of vaso-constriction. For the brain changes are those of a tissue loss caused by angiospasm; nothing suggesting vasodilation or stasis is present. The localized pathological changes in the horn of Ammon and the cerebellum are the *morphologically demonstrable result of angiospasm.* Apart from the theory, often propounded but as often combated, of the vasomotor origin of the convulsive seizure, the results of histological investigation are in accord with the bioptic observations of Foerster, Kennedy and others, who assert that pallor of the brain and shrinkage in its volume precede the convulsion, and that this is due to vasoconstriction of the cerebral vessels in the pre-paroxysmal stage.

The condition of angiospasm must be the prelude to the convulsion in every form of epilepsy. Of 126 cases of idiopathic and symptomatic epilepsy investigated by Spielmeyer in this connection, 20 per cent were negative with reference to locally circumscribed pathological changes; within this negative group there were present exactly the same clinical and anatomical types of the disease as in the positive majority of the cases, that is, the negative group included cases of traumatic epilepsy and of convulsions associated with focal and diffuse intracranial lesions, as well as cases of the idiopathic disease. It cannot be concluded, therefore, that a different mechanism, not vasomotor in nature, characterized these negative cases, even though the absence of the characteristic circumscribed lesions is not explicable.

That angiospasm produces these organic changes only in the cerebellum and in Ammon's horn must be due to peculiarities in the circulatory conditions in those regions—to the inadequacy and inconstancy of the blood supply in certain portions of the horn of Ammon and to the calibre of the network of vessels in the uppermost layer of the cerebellar cortex and likewise to the sudden change in the direction of the blood stream at the level of the Purkinje cells. Above all, however, one must take into consideration

an increased convulsive predisposition on the part of these particular areas. Important evidence in this direction is supplied by the findings of Weimann in connection with rapidly fatal carbon monoxide poisoning, in which the vulnerable portion of the cornu Ammonis showed a condition of anemia, while the neighboring regions were markedly hyperemic. The boundary between the hyperemic and the anemic area coincided with the curving line of demarcation which often separates the Ammon's horn sclerosis from healthy tissue.

Lesions with a bearing upon pathogenesis have been sought in the focus from which the convulsion first originates; this has been attempted in the portion of the cortex excised by Dr. Foerster in 36 cases. No changes were found in these, however, which could be interpreted as decisive in this direction, but only such as one finds in the epileptic brain in general, of which it is impossible to say to what extent they are the expression of the so-called epileptic process in the cortex and how far they may be related to the functional mechanism of the convulsion.

The characteristics which the various types of epilepsy have in common with respect to their anatomical substrate consist, therefore, in certain constant pathological changes which exhibit a predilection for certain sites. These changes find no expression in the clinical symptomatology; they furnish no clue to etiology; but they may be considered secondary phenomena which give us a certain insight into the process itself.

(The complete article will appear in a forthcoming issue of the *Zeitschrift f. d. gesamte Neurologie u. Psychiatrie.*)

In a communication of some 40 pages, entitled *The Genesis and Course of Experimental Convulsions,* W. Trendelenburg presents a rather comprehensive, in part historical, survey of the subject of experimental convulsions from the time of the pioneer experiments with electric stimulation of the cortex carried out in 1870 by Fritsch and Hitzig.[4]

4. In a concise review of the historical aspects of experimental epilepsy given by Dandy and Elman (Bull. Johns Hopkins Hosp., 1925, *36*, 40), it is stated that from an exhaustive article by Ito (D. Ztschr. f. Chir., 1899, *52*, 225 and 417), containing a full bibliography of the subject to 1899, "we learn that as early as 1824 Kellie, and in 1826 Piorry, produced convulsions by bleeding animals, and that in 1824 Ashley Cooper produced convulsions in dogs by depriving the brain of its blood supply through ligation of both internal carotid and both vertebral arteries; these experiments were repeated with the same results by Kussmaul and Tenner in 1857 . . . . But Victor Horsley long since (1892) called attention to the impossibility of placing any great value upon these experiments."—(H. A. B.)

After mentioning the various types of stimulus capable of evoking convulsions in the experimental animal—the faradic current, caloric stimuli, mechanical stimuli (as from pressure), chemical stimuli, general in their action (as absinthe, cocaine, camphor) or local (as creatine, choral hydrate, ether, chloroform, strychnine)—the writer discusses briefly the varying responsiveness to convulsants exhibited by different animals. To faradic stimulation the rabbit is stated to be the least susceptible, the dog the most. At the same time there is a rather wide difference among individual animals of the same species in the readiness with which they respond with a convulsion to a given stimulus—a difference in *Krampfbereitschaft* which is a conspicuous characteristic of the human subject, as was indeed amply attested by the cranial injuries of the war. Amantea, for example, was able to induce convulsions in about 25 per cent of the dogs in which he employed strychnine applied locally to the motor cortex. By this method it is possible to obtain only twitches of the muscles in question in the less susceptible dogs, but a typical epileptiform seizure in the more susceptible. Whether we can here speak of a pathological predisposition (Anlage) is open to question, since we know too little of the fundamental conditions that govern the individual readiness of convulsive response. Although systematic investigation of this point is so far lacking and would be desirable, we have some evidence for believing that certain factors play some part in this direction, such as conditions with respect to the cerebral circulation, the general state of nutrition, the age, the integrity of the endocrine system, etc. Unverricht and Albertoni have shown that in the dog atropine given subcutaneously increases the susceptibility of the cortex to faradic stimulation.

In the case of a convulsant agent of general dissemination, such as absinthe, the seizure emanates from the motor cortex and not from other parts of the cortex which are equally reached by the convulsant drug. In absinthe, according to Ossipow, the removal of the cortex of the temporal and occipital lobes is without influence upon the production of the seizure, while the clonic component of the convulsion is absent after removal of the motor cortex. In the case of electrical stimulation in experiments of this type there is always the possibility of the conduction of the current to areas more or less distant from the point of application; and it would, indeed,

be desirable to carry out experiments with stimuli incapable of transmission in this way, such as with caloric stimuli. At present, however, conclusive proof is lacking, so far as the writer is aware, that in the experimental animal epileptic seizures can be produced by stimuli applied elsewhere than to the motor area of the cortex.

As to the precise nature of the cortical stimulus: When we note that the epileptic seizure can be produced in the experimental animal by stimuli of such widely differing character from a physical or chemical standpoint, we are compelled to ask what specific mode of action is, in the last analysis, the particular occasion for the seizure. It is possible that this is of the nature of an anemia of the site of application of the stimulus; we know that when cocaine is used as a convulsant, marked pallor of the cortex ensues. It may be that caloric stimuli produce a local asphyxia as a result of an increase in metabolic processes within the cortex. It may be that electrical stimulation produces its effect by the medium of vasoconstriction.

So far as Trendelenburg has observed, a noticeable alteration in the vessels does not take place at the site of electrical stimulation. This was likewise the experience of Jacobi, who made very accurate observations with the help of the microscope and by means of microphotography, but was unable to demonstrate any changes in the vessels in connection with the seizure. It is true that pallor of the brain and retraction of the tissues from the trephine opening, as a result of vasoconstriction, has been observed after hyperventilation, but this phenomenon occurred independent of the epileptic seizure. MacDonald and Cobb found that in the case of absinthe convulsions in the rabbit an initial fall in the spinal fluid pressure occurred, followed by a rise. But here, since a pharmacological agent was employed, a general effect on the blood vessels not necessarily pertaining to the mechanism of release of the seizure cannot be excluded.

In the human subject Marburg and Ranzi have reported the appearance of swelling, hyperemia, and prolapse of the exposed brain during the seizure, but they were unable to determine whether the primary event consisted in these changes or in the convulsion. Tilman found that increased intracranial pressure occurred a few seconds after the onset of the seizure, but could, therefore, only be regarded as the consequence of the latter. In the human brain exposed at operation Foerster has observed anemia of the cortex

preceding the epileptic attack, and Spielmeyer, as is well known, believes that a functional spasm of the vessels is of fundamental significance in this connection. It is stated by Ossipow, indeed, that all smooth muscles go into spastic contraction in the convulsion; thus spasm of the cerebral vessels might occur at the very outset of a tonic seizure, yet this could not be regarded as the cause of the seizure. At all events, without further data than are at present available it is impossible to suppose that local changes in the circulation represent a common mode of genesis of the convulsive excitation in the case of any stimulus capable of inducing convulsions experimentally. Cerebral anemia may, however, favor the outbreak of a seizure, as is illustrated by the frequent effect of carotid compression in man.

It is often difficult to discover by observation in what order the various segments of the body take part in the convulsion; moreover, the succession may vary in the same subject. According to Ziehen the spread of the convulsion in the dog is best observed by stimulating the cortical area of the orbicularis oculi, when movements of the ear muscles, the platysma, the forelimbs and the hindlimbs follow in order; thus here the clonic component of the convulsion spreads from the site of stimulation in the order of the topographical arrangement of the cortical centres. According to Bubnoff and Heidenhain, the spread is simultaneously bilateral; upon stimulation of the area in the left hemisphere effecting closure of the right eye, the right eye, left eye, right forelimb, left forelimb, and the hindlimbs became involved in that order. Otherwise, the "march" of the convulsion is such that the hindlimbs are usually the first involved, and this is attributable to the greater excitability of their cortical centre; then the centres of the other side become involved, according to Spiegel in the order of their threshold of stimulation, which does not necessarily correspond with their topographical arrangement.

From the theoretical standpoint, it is an important observation that clonic spasms may occur without increased muscle tonus—that is, without the presence of the tonic component of the seizure. There are differences in this respect, however, in different species of animals; in monkeys in particular it is possible to obtain pure clonus, and Trendelenburg has observed this also in cats after injury to the cortex. He was able to demonstrate beyond question

that the muscle tonus was not increased in the short intervals of about one second's duration between the clonic movements produced by stimulation with strychnine of the cortical motor area for the arm in the monkey; and in agreement with this is the statement of Beritoff that in strychnine clonus the innervation of the flexors is associated with simultaneous inhibition of the extensors. On the other hand, attacks may consist of increased tonus without any signs of clonicity; this is the case in particular after extirpation of the cortex.

It follows from such observations as these that there is complete independence of the clonic and tonic components of the convulsion; and this raises the question whether the two kinds of seizure which ordinarily appear in association with each other and which usually dominate the clinical picture of epilepsy are not perhaps of totally different origin. Ziehen, as is well known, has replied that clonus arises from excitation of the cortex, and that increase in tonus, the tonic component of the convulsion, occurs as a result of excitation of the infracortical portions of the central nervous system; Bubnoff and Heidenhain, likewise, have assumed on the basis of experiments which they carried out on dogs that the primary seat of excitation is in the cortex, but that with the progress of the convulsion the other cortical and sub-cortical motor centres become implicated in an excitation independent of the locus originally stimulated.

Recent experimental observations have confirmed the teaching of Ziehen, especially perhaps those of Bechterew and Rothmann. The latter observed the occurrence of convulsions, three years after the operation, in a dog from which the forebrain had been removed; although clonic twitches occurred, to be sure, in the area supplied by the facial nerve, the extremities exhibited no clonic movements whatever and so far as they were concerned the convulsion was purely clonic. Samaja found, after removal of the motor cortex, an absence of the clonic component convulsion in dogs in which the cortex was stimulated electrically. Clonic manifestations are absent, moreover, in newborn kittens, in which the cortex is not excitable; these first appear upon stimulation about 18 days after birth. In the rabbit, on the other hand, removal of the cortex is without influence upon the character of the seizure, in which as before a clonic phase succeeds the tonic. Morita investigated the

effect of cocaine and of camphor upon normal rabbits as compared with that upon rabbits from which the cortex had been removed bilaterally. In the normal animals both these drugs induced a general tonic state followed at a short interval by clonic movements; after removal of the cortex, necessitating a larger dose of the drug, only the tonic component appeared, without the clonic. A similar result was obtained in dogs by Fineberg and Blumenthal. Of similar import are the experiments of Fuchs, who found that after removal of the cortex in the cat and in the rabbit, clonus induced by strychnine disappeared almost entirely; and a like observation has been made by Turtschaninow in the case of santonin convulsions in the dog and by Ossipow in absinthe convulsions. It will be recalled that Pike and Elsberg showed that several weeks after extirpation of the motor cortex tonic and clonic convulsions reappeared upon the administration of absinthe; but inferences from these secondary phenomena are scarcely applicable to the normal cortex. The investigations of Binswanger are in harmony with the foregoing, wherein he found that in both the rabbit and the dog the second phase of the epileptic seizure was absent from convulsions produced by stimuli applied to the medulla, and in the dog, indeed, there occurred only tonic spasm of the entire musculature, without other movements of any kind whatever.

If we may, therefore, regard it as an established fact that the clonic component of the convulsion is to be distinguished from the tonic component, not only in regard to its outward appearance, but also with respect to its seat of origin, and that clonus emanates only from the cortex, this merely confronts us with a number of difficult questions, not all of them discussed in the literature. Is the character of the muscular movements in clonus always the same, and what is their character? Is the tonic component of the seizure always the expression of an excitation which, though arising in the cortex, becomes straightway infracortical—an independent excitation? Or, in addition to the clonic component, does the tonic component originate also from the cortex? What is the location of the infracortical areas which mediate tonic convulsions? What is the relationship of the clonic convulsion to other tonic phenomena which are certainly infracortical, such as decerebrate rigidity in particular? How is it to be explained that *during* electrical stimulation, even when this is feeble, a tonic contraction of the muscles con-

trolled by the cortical area in question is obtained, but that the later effect of the stimulation is to produce purely clonic movements? How is it, furthermore, that in the case of a caloric stimulus only clonic movements are obtained during the period of stimulation?

Before considering these questions further, it is necessary to controvert an idea which is implicit in a good deal of published work, but which considerably outruns the facts—the assumption that the tonic component of the seizure is conditioned by excitation of sub-cortical areas only, and that the cortex gives rise only to the clonic component. Such an assumption is rendered doubtful in that, generally speaking, the convulsion begins with a tonic phase. It might be assumed that in the idiopathic form of epilepsy the excitation begins in fact in the sub-cortical region, and that from that region it is only secondarily that the cortex becomes involved in the excitation, whereby the clonic phase is initiated. But it is not possible to presuppose such a course of events in traumatic cases of epilepsy with cortical injury; moreover, the course run by the convulsion produced in dogs by faradic stimulation of the cortex controverts the assumption. Since, then, we cannot suppose that the convulsion from its beginning arises from an independent excitation of subcortical areas, we must concede that the cortex is capable of mediating purely tonic seizures.

The precise moment at which the excitation in the sub-cortical areas becomes independent of the cortical cannot be stated in general terms. It can only be given in the individual case by means of an experiment in which, during the course of a convulsion provoked by stimulation of the cortex, the cortex is thrown out of circuit by dissection or better by refrigeration; if the convulsion, even its tonic component, is thus terminated, the infracortical areas have not yet been aroused to independent excitation; but if, on the other hand, the tonic component persists, the now disconnected cortex is no longer taking part therein. Rothmann employed an ethyl chloride spray for cutting the cortex out of circuit; he succeeded in this way in inhibiting after three to five seconds seizures which had been induced by faradic stimulation of the cortex and had continued for 30-40 seconds. In this instance, therefore, the excitation had implicated the cortex only—had not, at any rate, been transmitted as an independent excitation to the sub-cortical structures. If this view is correct—and it is difficult to see what other interpre-

tation can be put upon this experiment—we have no ground for supposing even in the case of human epilepsy that a pure tonic seizure can arise and run its course without the participation of an excitation of the cortex.

In sum, it may be said that the tonic component of the epileptic seizure originates and is maintained under the direction of excitation of the cortex, but that it may also be maintained by means of a subsequently independent excitation of sub-cortical areas.

To consider a little further the clonic component of the convulsion; if it be assumed that the cerebral cortex manifests a refractory phase of not inconsiderable duration, then the series of clonic twitches such as are induced, for example, by a caloric stimulus would correspond fully to what we observe when the heart muscle is stimulated with a galvanic current. The cortical stimulus gives rise to such a momentary muscular contraction, after which the cortex is refractory for about half a second; at the end of this refractory period the stimulus acts in the manner of a new stimulus suddenly applied, and the cycle is repeated. The infra-cortical structures, however, may have no refractory phase or only a very brief one. If these are brought into an independent state of excitation, they will transmit the latter to the nerves and muscles in the form of a continuous excitation of extremely rapid rhythm, so that the muscles fall into a state of tonus—the "tetanus" of muscle physiology. As a matter of fact, Broca and Richet have been able to demonstrate a refractory phase of appreciable duration by electric stimulation of the cortex. Zwaardemaker has shown the same tc be true of the swallowing and winking reflexes; in both these instances the refractory phase was particularly long, one to three seconds in duration, while in the experiments of Broca and Richet it was of 0.1 to 0.7 seconds' duration, according to the temperature. Further investigation, with some inquiry into the bearing of the strength of the stimulus, would be necessary to obtain further insight into the relationship of these phenomena to clonus.[5]

How is the excitation transmitted from the primary site of stimulation in the cortex? Ewald obviated the spread of the stimulus itself by implanting in the cortex small thin-walled glass tubes which projected slightly above the surface; he thus indicated the

5. That a phase of increased excitability follows the refractory phase has been shown by Isayama. In his recently published book on epilepsy, Muskens has treated the question of the refractory phase in some detail.

site of primary stimulation, not only with reference to the transmission of the excitation via the association fibres, but also to the spread of the stimulus by conduction of the current. Under these circumstances spread of the convulsive excitation no longer occurred. That the excitation is disseminated in the homolateral cortex itself is likewise suggested by the demonstration of Ziehen and by Bubnoff and Heidenhain that the further spread of the convulsion could be interrupted if during its course the primary site of excitation were quickly extirpated; furthermore, no clonic movements made their appearance in the muscle groups of which the corresponding cortex had been removed.

As to the passage of the excitation to the opposite half of the brain, Lewandowsky declared that the corpus callosum acts as the medium of transmission, and Horsley's experiments on dogs suggest the importance of this structure in effecting this transmission. Horsley found that after cutting through the corpus callosum and the commissures the effect of the cortical stimulus in the form of tonus followed by clonus appeared in full only in the contralateral extremities, while the effect upon the side of the stimulus consisted merely in a condition of feeble tonus or in none at all. Karplus, however, was unable to verify this observation in either the dog or the monkey; he demonstrated that after cutting through the corpus callosum, stimulation of the right half of the cortex gave rise to clonic movements on the part of the muscles of the left side of the body, while the extremities on the right side might also become involved, although not with the same intensity as upon the left side. If in addition the right cortex was removed and the left then stimulated, the extremities controlled by the right cortex still participated in the tonic phase of the convulsion but no longer in the clonic. Hence it is apparent that even after cutting through the corpus callosum the opposite half of the cortex takes part in the excitation. Spiegel obtained a similar result and showed besides that the generalization of the convulsion was not prevented by division of the commissures. We see, therefore, that the corpus callosum does not take part in the transmission of the epileptic excitement—or, more accurately expressed, we are unable to demonstrate its participation. Much remains obscure with reference to the pathways by which the excitation aroused by the original stimulation of the cortex is transmitted to the sub-cortical region, the structures in the

latter which are involved in the transmission of the excitation to the opposite hemisphere, and the pathways by which the excitation then reaches the cortex of that hemisphere.

As to the descending pathway along which the excitation is conducted, the pyramidal tracts would naturally occur to one as being the most important; but these do not appear to have the preponderant role formerly attributed to them. Hering showed that clonic spasms could occur in a dog when the pyramidal tracts had been disconnected; the converse was also true, and the pyramidal tracts mediated the clonic spasm when the remaining tracts were out of circuit. Economo and Karplus showed that all the usual consequences of electrical stimulation of the cortex took place in the cat when the pedunculi cerebri were cut through. The pyramidal tracts play a more important part in the monkey, however, for, according to Hering, clonic movements of the extremities no longer occur when these have been divided, though still observable in the head, eyes and face.

Regarding the point at which the excitation passes to the opposite side, Karplus has shown that it is not located in the spinal cord. Spiegel has furthermore shown that none of the transverse tracts anterior to the rhombencephalon are required for this. How the excitation reaches the rhombencephalon from the cortex is still unknown. The frontal and temporal cortico-pontine tracts are not involved.

One important question remains to be considered: In the production of the tonic component of the convulsion, is the same mechanism in question as produces tonic excitation in various other conditions? Decerebrate rigidity comes to mind as an example of the latter—likewise insulin convulsions, the convulsions associated with hyperventilation and asphyxia, and parathyreoid tetany. Without discussing this complicated question at any length, it may be said that it is not probable that a mechanism is operative in the tonic seizures of epilepsy which is dissimilar from that present in other conditions of muscular hypertonia, nor is it very likely that this mechanism is widely different from that of the maintenance of normal tonus. But here we must confine ourselves to the question of the relation of the tonic spasm in epilepsy to decerebrate rigidity.

While no entirely satisfactory answer has as yet been forthcoming to the question whether decerebrate rigidity is a phenomenon

of stimulation or of inhibition (the experiments of Economo and Karplus, Bazett and Penfield, and Magnus and Rademaker, who produced decerebrate rigidity of considerable duration, suggest the latter explanation), the locus of the phenomenon, at least, has apparently been established. Rademaker has shown that tonus remains unimpaired when section is made directly anterior to the red nucleus, but that decerebrate rigidity makes its appearance when it is made immediately caudal to it. Section of the rubrospinal tracts at their decussation likewise produces decerebrate rigidity. There can be no doubt but that the red nucleus plays an important part in this phenomenon. If we assume with Rademaker that this is also the case in man, the question whether stimulation or a cutting out of circuit is involved is not pertinent to the inquiry as to the relation to decerebrate rigidity of the tonic component of the epileptic seizure, for epileptic tonus is certainly a phenomenon of "stimulation" in the usual sense of the word. Nevertheless, further investigation is required before we can approximate a solution of the complex question of the relation of epileptic rigidity to other rigidity states. The situation is made more difficult by the fact that, apart from the red nucleus, we know too little regarding which structures in the deeper portions of the central nervous system are involved in the production of tonic manifestations. The same uncertainty, indeed, confronts us here as did regarding the question of the point at which the convulsive excitation passes from the site of stimulation in the brain to the opposite hemisphere, of the manner in which the excitation arrives at this point, and of how it is then transmitted to the cortex of the opposite hemisphere. The locus in the nervous system of the excitation which underlies the phenomenon of rigidity is presumably the same in epilepsy, decerebrate rigidity and tetany, and likewise in other conditions (asphyxial and hypoglycemic convulsions, for example) with which increased tonus is associated. According to Spiegel and to Kleitmann and Magnus, this locus is to be sought in the rhombencephalon.

THE REGULATION OF CHLORIDE-BROMIDE INTAKE IN EPILEPSY*

BY. DR. J. NOTKIN,

SENIOR ASSISTANT PHYSICIAN, MANHATTAN STATE HOSPITAL, NEW YORK CITY; ASSOCIATE IN NEUROLOGY, NEW YORK POST-GRADUATE MEDICAL SCHOOL AND HOSPITAL

As the cause of epilepsy is still undetermined, therapy necessarily remains symptomatic and must limit itself to the control of the convulsive seizures. A number of drugs have been advocated for this purpose, among others, at first bromides, in later years, Luminal. Simplicity of technique with the latter form of medication won great favor for this drug. However, complete cessation of seizures with Luminal has been reported only in isolated cases, and in numerous others it did not reduce their number to any great extent. A more efficient drug was sought; but in the absence of one, as frequently happens, recourse was again had to the older remedy, and renewed attempts were made to improve the technique of bromide medication. After the experimental work of the Zurich school became known, bromine came again into the limelight. The early difficulties with bromine were largely due to the fact that at first the drug was used rather indiscriminately. Even today, there still exists much confusion as to the physio-chemical processes set up by this medication. In regard to this intricate problem we shall not go into the controversy among different workers. It may merely be mentioned here that two theories have been advanced, one—the theory of hypo-chloridation as a result of bromide medication, the other—the theory of the specific action of bromides on the central nervous system. As to the theory of hypo-chloridation, our experiments do not indicate that this is an important factor in every case. Out of seven patients who were put on a high table salt diet, (from 20.0 to 30.0 grams a day) 3 had an increased number of seizures, while 4 showed no response at all. The fact that over 50 per cent did not respond to the hyper-chloridation would point to a different pathology in these cases and may perhaps give us an idea of a difference in etiological factors in the epilepsies.

Bernoulli and Ulrich, who in recent years have done considerable work on this problem, state that neither hypo-chloridation alone

* Read at the annual meeting of the National Association for the Study of Epilepsy at Cincinnati, May 31, 1927.

nor the control of the amounts of bromide administered is of much benefit. What is necessary is that a certain amount of sodium chloride in the organism be substituted by sodium bromide and that a definite and constant quantitative ratio between the two halogens be maintained at all times. This is possible only if the intake of the two halogens is also kept at a definite ratio. In other words, with the bromide, the amount of table salt in the diet has also to be supervised. The figure which expresses the percentage of sodium chloride substituted in the system by bromide is called the "relative bromide content." In Bernoulli's and Ulrich's observations this relative bromide content runs from 10 to 30. In those of their cases in which the relative bromide content ran near the latter figure, signs of bromide poisoning became apparent. As will be seen from our table, the relative bromide content in our cases generally averages between 26 and 28. However, there are some instances with a relative bromide content as low as 1.13 or as high as 45 without any signs of bromide poisoning in the latter case, and with good effect as to the control of the number of seizures in all instances.

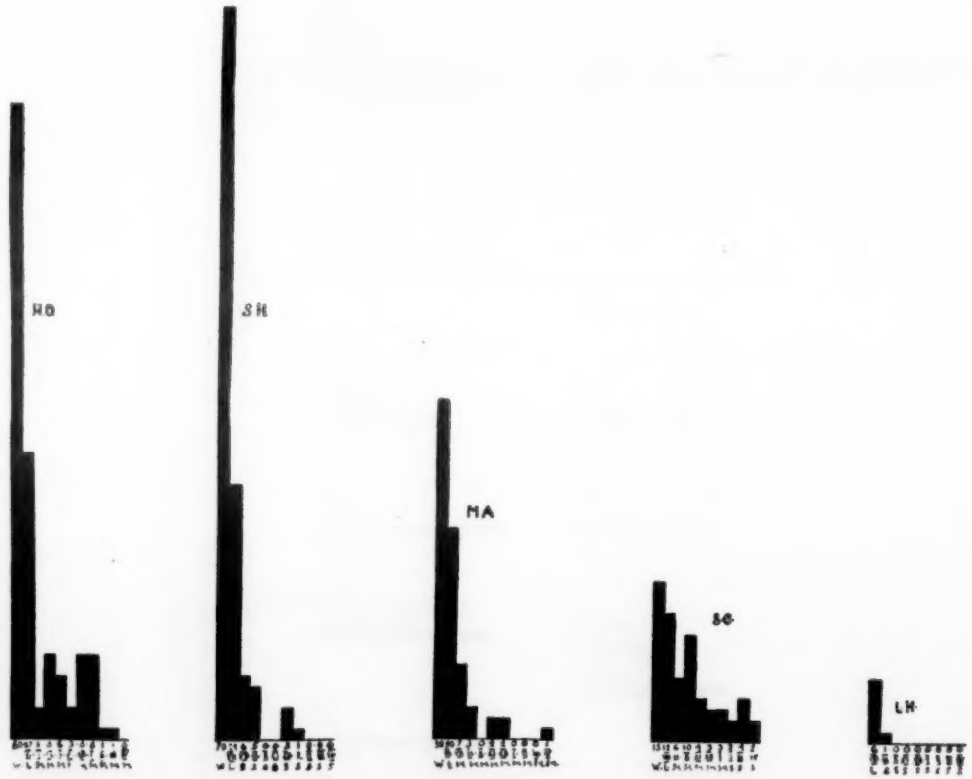
To regulate the intake of sodium chloride a modified method of therapy was introduced some years ago by Ulrich in Zurich. Calculating the amount of table salt in the diet as ranging between 10 and 15 grams a day, he administers small bouillon cubes containing 1.1 gram of sodium bromide, 0.1 of sodium chloride, vegetable proteins and seasoning, a preparation known as Sedobrol "Roche." This is given in the form of broth or soup and is very palatable.

Our experience with Sedobrol dates back over eight years, and we have throughout been impressed with its superiority over Luminal. The first observations, however, were sporadic and there was no opportunity for a detailed or careful study. During the past several months, out of the large number of epileptic patients at Manhattan State Hospital, New York City, it was possible for us to select for systematic study a group of patients who did not respond favorably to Luminal therapy. Later we included in this group some recently admitted cases, keeping them without therapy for a while as controls and then putting them on Sedobrol. In the cases with a very high number of seizures we did not discontinue Luminal entirely as we feared the effects of Luminal cessation, but we reduced the Luminal dose to ¾ of a grain daily and added at the

beginning two tablets of Sedobrol, increasing later up to five or six tablets, but not higher. The result (as will be seen in the tables) was that all the cases put on this treatment immediately responded with a decreased number of attacks, continuing so up to the present time. In one severe case with about 65 seizures a month under Luminal treatment we first decreased Luminal to ¾ of a grain and used three tablets of Sedobrol daily. The number of attacks decreased to two a month and after a slight exacerbation the number of seizures was finally reduced to zero with Sedobrol only.

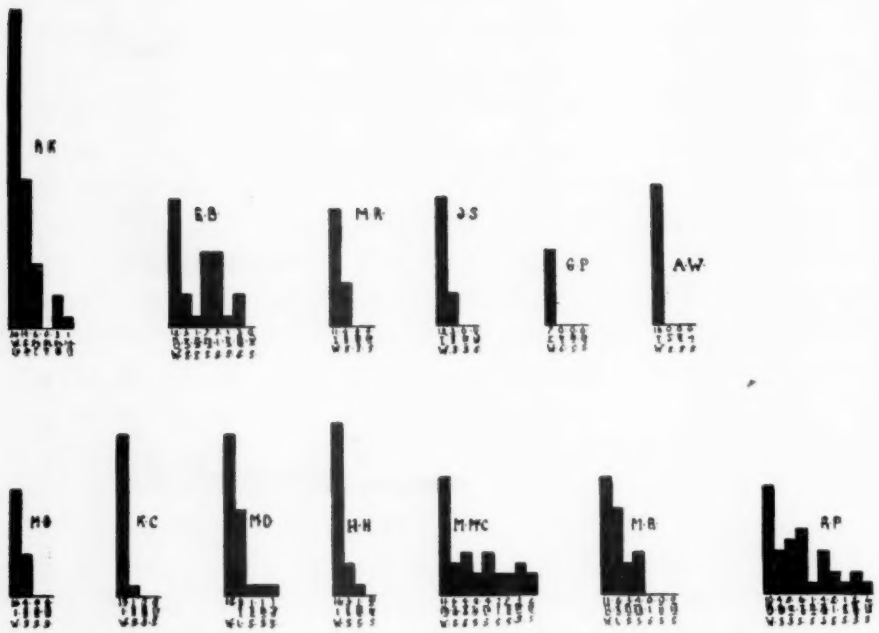
In another case with severe status of 10 to 15 seizures daily a combination of ¾ of a grain of Luminal and four tablets of Sedobrol has reduced the number of seizures to three a month, and at the present time the patient is entirely free from seizures. In two other cases, one with an average of about 25 seizures a month, the other of about 15, under Luminal therapy, we first reduced Luminal to half a dose, adding three to four tablets of Sedobrol. After a few months we discontinued Luminal entirely, in each case reducing the number of seizures so far to two a month. In a few cases with a moderate number of seizures under Luminal we discontinued Luminal entirely and substituted Sedobrol, effecting a complete cessation of seizures. One patient, an elderly woman of 73 years of age, who suffered severe seizures practically every day under Luminal treatment, was put on Sedobrol until the number of seizures was reduced in the first 15 days to seven of a very mild type. This patient's condition was complicated by a severe cardiac lesion and she died of an aortic insufficiency on September 15, 1926, with complete clearness of sensorium and freedom from seizures for five days previous to her death. Another patient, 31 years of age with a myoclonic type of epilepsy, who had been bedridden for several years and was extremely emaciated physically, showed no response to Luminal therapy. In January of this year we started to give her Sedobrol; the number of seizures was reduced to two a month, but she grew weaker and finally died March 21, 1927.

Our group consisted of 34 patients, two of whom have been released from the hospital but are under our treatment at home, two (mentioned above) died, and 30 are under treatment at the present time in the hospital. Three of them are on combined treatment with Luminal and Sedobrol, of which the dosage of Luminal



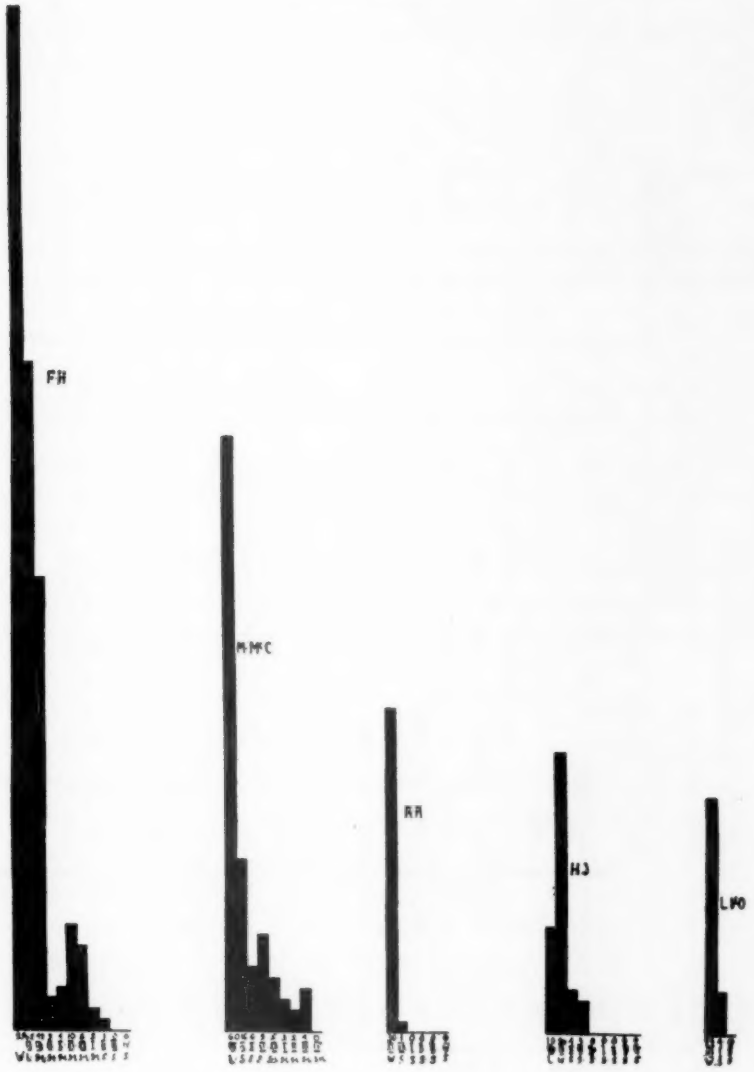
FREQUENCY OF SEIZURES PER MONTH OF INDIVIDUAL PATIENTS

Roman figures represent months. "L" = Luminal. "S" = Sedobrol. "L" and "S" = combined treatment. "W" = without treatment.



FREQUENCY OF SEIZURES PER MONTH OF INDIVIDUAL PATIENTS

Roman figures represent months. "L" = Luminal. "S" = Sedobrol. "L" and "S" = combined treatment. "W" = without treatment.



FREQUENCY OF SEIZURES PER MONTH OF INDIVIDUAL PATIENTS

Roman figures represent month. "L" = Luminal. "S" = Sedobrol. "L" and "S" = combined treatment. "W" = without treatment.

CHLOR - BROMINE METABOLISM IN EPILEPSY

NAME	BLOOD			URINE			VOL. OF URINE IN 24 H.	AMT. NaBr DAILY	AMT. NaBr. EXC.	RELATIVE BR-CONTENT IN BLOOD	RELATIVE BR-CONTENT IN URINE
	NaCl	NaBr	TOTAL	NaCl	NaBr	TOTAL	C.C.	G.	G.		
	Mg./100 C.C.			Mg./100 C.C.							
L. M.	488	15	503	475	40	515	1.350	3.3	.54	2.98	7.78
"	371	223	594	232	127	359	1.700	3.3	2.2	37.54	38.37
E. R.	524	6	530	791	224	1.015	1.500	4.4	3.36	1.13	22.07
A. W.	497	25	522	230	87	267	3.150	2.2	.85	4.79	10.50
"	410	128	538	55	27	82	1.000	2.2	.27	23.79	32.92
M. R.	310	123	433	632	164	796	1.700	3.3	2.78	28.40	20.60
F. H.	243	193	436	273	126	399	2.300	4.4	2.9	44.26	31.57
M.Mc C.	424	181	605	735	468	1.203	1.500	4.4	7.0	29.91	38.90
S. C.	436	31	467	379	95	474	1.500	2.2	1.4	6.63	20.04
G. P.	363	109	472	220	25	245	960	2.2	.24	23.09	10.20
"	363	209	572	260	89	349	900	2.2	.80	36.53	25.25
S. M.	392	135	527	289	26	315	1.440	3.3	.37	25.61	8.25
"	369	203	572	87	33	120	1.500	3.3	.50	35.49	27.50
R. P.	351	190	541	707	331	1.038	1.000	3.3	3.3	35.12	31.88
A. S.	404	115	519	493	122	615	1.300	2.2	1.6	22.15	19.83
J. S.	380	180	560	668	277	945	1.500	4.4	4.2	32.14	29.31
H. H.	412	175	587	728	233	961	1.200	2.2	2.8	29.81	24.24
H. J.	392	161	553	847	342	1.189	1.500	3.3	5.1	29.11	28.76
M. McCl.	328	275	603	460	261	721	1.300	4.4	3.1	45.60	36.19

*)Repeated.

is ¾ of a grain and of Sedobrol not higher than six tablets; the rest are on Sedobrol only.

In regard to bad effects from bromide treatment, we may say that out of the whole group only two have had signs of bromism; one developed a severe form of bromoderma tuberosa with signs of bromine poisoning, and one showed general signs of bromine intoxication. Both of them became somnolent, drowsy and quite weak, with high pulse and temperature, unsteady gait and defective speech. The oral administration of salt solution had a remarkable effect on these patients; they immediately brightened up and in a few days recovered completely. Bromide therapy has not been discontinued in these cases but we continued giving them, along with Sedobrol, 2.5 to 5.0 grams of table salt daily, and since then we have not seen any signs of bromism except acne in two other cases.

One would expect from the early conceptions, particularly of Marchand and Toulouse, a decrease in the action of bromide by addition of table salt. Ulrich in his early works also maintained the same idea but in his recent experiments has abandoned it, and now adds table salt to his bromide in a number of cases.

Both weight and blood pressure readings were regularly taken, and both usually decreased during the first week of treatment, but soon afterwards they gradually increased, the weight nearing normal and occasionally going higher, blood pressure approximating normal but not reaching it.

As to the mental condition of the patients, interesting observations have been made. It is known that bromide usually provokes a state of euphoria; however, in a number of our cases we observed in the beginning a depression with dejection and general retardation; others were typically euphoric, talkative, elated, generally hypomanic. This makes us rather inclined to think that the bromide is not acting in a specific manner to provoke a state of euphoria but is bringing to the surface the innate type of personality, perhaps in a more or less exaggerated form. As the treatment progressed all of the patients quieted down again. The seizures if they occurred were very slight in type and of a short duration. Equivalents have not been observed.

In regard to deterioration, from our experience with this therapy we have not noted that the bromide increases deterioration as has been previously maintained; we observed rather a brightening up.

We refer particularly to a few patients who had apparently reached the ultimate degree of mental disintegration—they would not utter a word, their facial expression was blank, eyes lifeless. During treatment they started again to move about, even helping a little on the ward. In general, they also became more manageable. This holds for the whole group, especially patients whose deterioration was not so advanced.

Summary

In summing up we may state that 34 patients have been treated with Sedobrol from four to nine months; 31 with Sedobrol alone and three with a combination of Sedobrol and Luminal. Two patients died during the course of treatment, one of aortic insufficiency, the other of general physical debility. All of the patients showed a very good response to the treatment, the majority remaining free from seizures for as long as seven months. They also improved mentally and physically. In regard to the technique of bromide medication our experience with it taught us that the administration of larger doses of bromide is unnecessary and dangerous. It is sufficient to start with one cube of Sedobrol per day (17 grains of sodium bromide) and increase the number of cubes after short intervals until the maximum optimal dose is reached, that is, the dose which gives the best response without producing any signs of bromine poisoning. Except for the elimination of salty food such as cheese, sardines, etc., we did not diminish the usual amount of table salt in the daily food (about 15.0 grams per day). In the two cases of severe bromism we reduced the amount of Sedobrol, but did not eliminate it entirely. We added table salt to the food up to 5 grams per day. The dermal manifestations were successfully treated by this addition of table salt and with the application of wet dressings of a saturated solution of sodium chloride. Along with it, sodium cacodylate, 0.5 grain to one dram solution was given once or twice daily. In cases of severe bromine poisoning where the oral administration of table salt is impossible an enema of normal saline solution is very effective. In aggravated cases of epilepsy with frequent daily seizures a combination of Luminal and Sedobrol has proven very effective.

Bibliography

Toulouse, Ed.

Traitement de l'Epilepsie par les Bromures et l'Hypochloruration. Revus de Psychiatrie 4, 1900.

V. Wyss, H.

Die pharmakologischen Grundlagen der Bromtherapie bei der genuinen Epilepsie. Deutsche Med. Wochenschrift 39, 1913.

Ulrich, A.

Beitrag zur Technik der wirksamen Bromhehandlung der Epilepsie. Correspondenz-Blatt für Schweizer Aerzte 21, 1914.

Die Halogenanalyse des Urins and ihr praktischer Wert in der Bromtherapie. Schweizer. Archiv für Neurologie & Psychiatrie, 13, 1923.

Bernoulli, E.

Zur Dosierung der Bromsalze bei Epilepsie & Depressionszustanden. Corr.-Blatt für Schweizer Aerzte. 32, 1917.

THE ŒDIPUS AND HOMOSEXUAL COMPLEXES IN SCHIZOPHRENIA

(A SECOND COMMUNICATION)

BY THEODORE R. ROBIE, M. D.,
ASSISTANT PHYSICIAN, HUDSON RIVER STATE HOSPITAL

In a previous paper[1] attention has been called to the fact that in by far the greater proportion of cases of schizophrenia the existence of an Œdipus complex can be demonstrated, either objectively or subjectively, or by both methods; and that in a relatively large number of those cases in which an Œdipus complex can be demonstrated, a coexistent homosexual complex can also be demonstrated. In certain cases it is apparently possible to demonstrate the presence of only one of these complexes, but as a rule, where either one of them is plainly demonstrated, we can with a fair degree of accuracy, postulate the presence of the other.

In view of the very frequent association of a pathological Œdipus situation with homosexuality, in a given subject (and vice versa), an explanation of the causation of this relationship would seem desirable. An understanding of this point will be of value both for the sake of clarifying the problem we are studying, as it would be a further help in the understanding of the cases we see daily, as well as those described below. The most satisfactory, available explanation of this relationship is that given by Freud. His explanation however is not claimed by him to be final, or perfect, since he does not believe that psychoanalysis can solve the problem of homosexuality, as the definition of the terms "masculine" and "feminine" must first of all be determined by biology. In spite of this fact, however, his method of approach to the problem of homosexuality is the best one available at the present time, and the explanation he offers of the psychogenesis of homosexuality from the pre-existing Œdipus attitude, is a most excellent one. From his analysis of a case of female homosexuality (the case was that of a beautiful and clever girl of eighteen) Freud[2] traces the development of her inversion. This girl became infatuated with a woman of ill repute (a known demi-mondaine) to the exclusion of

1. Robie.—The Investigation of the Œdipus and Homosexual Complexes in Schizophrenia, PSYCHIATRIC QUARTERLY, Vol. 1 No. 2, April, 1927.

2. Sigmund Freud. On the Psychogenesis of a Case of Female Homosexuality, Int. Jour. of Psychoanalysis, Vol. 1, No. 2, 1920.

all other interests. (It was known that this woman lived with a married woman-friend, having intimate relations with her, while at the same time she carried on promiscuously with a number of men.[3]) Her infatuation finally led to an attempt at suicide. Soon after this occurrence she came under Freud's care. In his analysis he found the psychological motive of these abnormal conditions to be an unconscious desire on the part of the girl for revenge on the father, or, otherwise expressed, an over-reaction to a father fixation. There had been a strong fixation of affection on the father, but when repulsed she defied him (ambivalent reaction). The result of this was her final homosexual attitude. She excluded men from the field of interest—a repudiation or rejection of the unattainable, i. e. the father. Thus, Freud states, the source of homosexuality in the female is found to be the same as in the male, with the sexual signs of the object reversed, i. e. in the Œdipus complex.

"The fact was established beyond doubt that this change (to homosexuality) occurred simultaneously with a certain event in the family, and one may therefore look to this for some explanation of the change. Before it happened, her libido was focussed on motherhood, while afterwards she was a homosexual attracted to mature women, and remained so ever since. The event referred to, which is so significant for our understanding of the case, was a further pregnancy of her mother, and the birth of a third brother, when she was about sixteen.

"The analysis revealed beyond all shadow of doubt that the beloved lady (with whom the patient was infatuated) was a substitute for—the mother . . . . The explanation is as follows: When the girl suffered her disappointment, she was just experiencing the revival of the infantile Œdipus complex so common at puberty. She was keenly conscious of the wish to have a child, and a male one; that it was to be from her father, and in his image, her con-

3. To digress for a moment, it is interesting to note in this connection that Boehm,[4] who has made a rather extensive study of the question of homosexuality, arrives at the conclusion that the heterosexual impulse is related to monogamy while the homosexual tendency leads to polygamous activities, and briefly expresses this relationship in the form of a geometrical proportion i. e. Heterosexuality: Monogamy:: Homosexuality: Polygamy. He regards the brothel as the instrument of homosexuality, and a house of ill repute as a disguised means of satisfying homosexuality. Through the intermediation of the promiscuous woman the homosexual man indulges his inclination for the absent sex; in the last analysis it is the mother to whom his attachment has remained fixed, whom he is seeking.

4. Felix Boehm. Contributions to the Psychology of Homosexuality. Int. Jour. of Psychoanalysis, Vol. VI, No. 4.

sciousness was not allowed to know. And then: It was not she who bore the child, but the unconsciously hated rival, her mother. Exasperated and embittered, she turned away from the father, and from men altogether. After this first great reverse she foreswore her womanhood, and sought another goal for her libido. . . . . She changed into a man, and took her mother in place of her father, as her love-object. (It is by no means rare for a love relation to be broken off by means of a process of identification on the part of the lover with the loved object, a process equivalent to a kind of regression to narcissism. After this has been accomplished, it is easy in making a fresh choice of object to apply the libido to a member of the sex opposite to that of the earlier choice.) Since there was little to be done with the real mother (there was little love between the two), there arose from the conversion of feeling just described the search for a mother-substitute to whom she could become passionately attached. (She fixed her attachment to the demi-mondaine as the mother substitute.)

"The attitude of the libido thus adopted was greatly reinforced as soon as the girl perceived how much it displeased the father (i. e. her infatuation with the woman of questionable reputation). . . . . She realized how she could hurt her father and take revenge on him. Henceforth she remained homosexual out of defiance against her father. She *wanted* her father to know occasionally of her intercourse with the lady, otherwise it would mean her missing the satisfaction of her keenest desire—namely, revenge. So she saw to this by showing herself openly in the company of her adored friend, by taking walks in the streets near her father's place of business, and the like."

Freud does not maintain that every girl who experiences a disappointment of this kind in the love longing that emanates from the Œdipus attitude of puberty necessarily on that account falls a victim to homosexuality. He believes that there are present special factors, probably of an internal nature, that help turn the scale, in those cases that do become homosexual. At present, however, we are unable to explain the full nature of these particular factors. He calls attention, however, in his closing remarks to "two fundamental facts which have been revealed by psychoanalytic investigation. The first of these is that homosexual men have experienced a specially strong fixation in regard to the mother; the second, that,

in addition to their manifest heterosexuxality, a very considerable measure of latent or unconscious homosexuality can be detected in all normal people. If we take these findings into account, then the supposition that nature in a freakish mood created a "third sex" undoubtedly falls to the ground."

Since Freud does not claim absolute infallibility for his deductions, it is possible that this formulation of a theory concerning the development of homosexuality may have to be changed in the future. However, for the present we can postulate, that some such modus operandi is the basis for the development of homosexuality, though there will undoubtedly be individual points of variation in different cases. It would be practically impossible to find two cases that had passed through exactly the same developmental chain of events, sex traumata, etc. In the study of this factor in dementia præcox cases we are necessarily limited in the scope of our work, since we are dealing in practically all cases with evasive and incooperative individuals. It is this type of case that is renowned for inaccessibility.

In the minds of most people an homosexual affair of any kind is an unthinkable, asocial and tabooed thing. When, therefore, homosexual cravings appear in consciousness, the person who is subject to such perverse cravings becomes at once frightened at, and later disgusted with himself for allowing such thoughts to enter his mind. Yet in spite of this auto-censorship of his cravings, which he realizes are perverse, he is nevertheless unable to blot them out of consciousness, as the cravings are strong and tend to become stronger when no kind of relief for them is forthcoming. This increase in craving is similar in its action to the normal increase in heterosexual desire which occurs as a result of abstinence from heterosexual relations.

When a person possessing an introverted or schizoid personality is subject to perverse homosexual cravings one of the possible reactions thereto is in certain cases, a psychosis. Being of an extremely sensitive disposition, these homosexual cravings seem to him infinitely worse than they would to the average more extroverted person. Yet he is unable to throw these feelings out of consciousness easily —both because of the strength of the cravings and because, being of the introverted (thinker) type, his mind is prone to think more on such subjects than would another, more extroverted person.

Therefore, in order to rid himself consciously of the thoughts that distress him he develops various delusional ideas, and also hallucinations. He allows himself to satisfy through his psychosis, those perverse cravings which he could not with impunity allow himself to satisfy by an actual homosexual affair in his previous sane condition. He hears voices calling him bad names, such as c. s., s. o. b., fairy, etc., and other names referring to homosexuality. Since such manifestations of psychoses are recognized as being purely wish-fulfilling in nature, it is not at all difficult to understand that the schizophrenic patient who hears himself called such degrading names is unconsciously receiving definite satisfaction of his homosexual cravings (libido). If he will allow himself to go so far as to admit to other persons that he is called names (by imaginary people) that decry him as an homosexual person, he is in all probability, in his phantasies, carrying on a veritable orgy of homosexual practices.

The schizophrenic of course, lacking as he is in insight, does not appreciate the fact that when he tells a psychiatrist that he hears voices calling him c. s., fairy, etc., he is really telling him the nature of his unconscious cravings—so that he therefore might just as well have said to the psychiatrist, "I want to be a c. s.—I want to perform fellatio," for that is the interpretation that is placed on his hallucinations. A similar interpretation would of course be placed upon hallucinations of incest. When a man becomes distressed because he hears imaginary voices telling him he has been having intercourse with his mother, the inference is perfectly clear that he would be saying, if he dared, "I want to have sexual relations with my mother."

The practically constant association of the Œdipus complex with homosexuality has been demonstrated to the satisfaction of the writer in a number of cases of schizophrenia. Two cases will be given in detail to make this point clear. The cases selected are chosen as fair representatives of a large group of cases available, in which similar mechanisms are demonstrable.

Case I. V. B. H. Admitted to Hudson River State Hospital, April 28, 1927. Male. Age 30. Born in U. S., of mixed German and English race. Single. Two paternal uncles were insane (diagnosis unknown). His father, a follower of horse racing, divorced patient's mother 24 years ago. He was a moral man but indifferent

to his family. Patient's mother a very neurotic person, says she has been in poor health and "nervous" for 27 years with "complications of diseases" (heart, kidneys, etc.—own statement). Occupation after divorce, boarding house matron; for past five years after home was broken up she and patient have been living alternately with the two married daughters. There were five children in family—patient and four daughters, two of whom are dead (first, pneumonia; second, diabetes), and the other two are married. Prior to patient's birth, mother was physically weak and under emotional stress due to domestic difficulties (husband incompatible). Birth was normal however, but patient was a nervous child. Had tendency to twitch and claimed he felt a sensation like worms crawling over his body at such times. He attained a common school education (seventh grade), but was a poor student. He was a Congregationalist originally but during past 12 years studied Christian Science and was treated by their practitioners, but five years ago following death of sister, he lost confidence even in this.

From ages 9 to 14 a Mr. L. took an active interest in patient, who idolized the man. This attachment was a very close one, and patient spent one summer on a farm with this man, and it is probable they slept together (a brother of this man was an asylum inmate. Further information is lacking). Sister states patient's first neurotic symptoms were noted shortly after Mr. L. dropped him, and the first one was the abnormal desire to wash his hands constantly—age was 14 then. Occupational career: He has never been self-supporting; wanted to get in "movies" or on the stage as a dancer. Maximum wage earned $12 per week when trying out as a dancer in a musical show. During past six years he has made no effort to be self-supporting. Personality: Impulsive; quick-tempered; never self-reliant; sociable; cheerful; good mixer; well liked. No real love affairs but did go about with girls; jealous, judgment was poor. Humored by mother all his life; made to feel he was ill, and she has constantly waited on him so he never had to depend upon himself. Self-centered, never a leader. Said to have enjoyed social life, dancing, and theatre. Played piano well. (Considering the history of the mother who was informant some of these statements may be questioned.)

During entire life has been rather abnormal and subject to various fears. Has never been practical, showed poor judgment. Satis-

fied to live along and let family maintain him. During adolescence his fears and compulsions became more pronounced, and because of this he took up Christian Science 13 years ago in order to be cured (though secretly he never really wanted to be cured as that would remove the excuse for the constant pampering he demanded and secured from his mother as well as his two sisters). He gave up Christian Science, however, after the practitioners were unable to save his sister five years ago. Is described as "going to smash" following this sister's death and the mother admits that at that time she had to sleep with him at night, as he was too frightened to remain alone. During the past five years has shown various symptoms. He had a fear of death. He became very methodical in all his habits such as rising at a definite time each morning; a fixed time for cleaning his toes; shaking his underclothing, trousers, shoes, etc., before putting them on; then spending one-half to one hour in the bathroom at stool until "the slime" comes (this means "semen" to him); then a lengthy period of washing his hands; then rinsing and gargling mouth by a special process; special rules for eating food; absolute quiet must prevail during the process. It was sometimes necessary to repeat the whole procedure which took several hours. He had a great fear of spoons, knives and forks, scissors, razors or other sharp articles. He was also afraid of crowds, especially of men. He washed his hands very frequently —after each operation he performed during a day's time, and in drying his hands he held the towel over his head in order to avoid contamination. For past year mother has humored him to an extreme degree, waiting on him as though he were an invalid, serving all meals in a special manner, one dish at a time. If anything touched a dish, it would have to be rewashed before he would eat from it. He would remove part of his underwear before his meals and his mother would remove his shoes and roll down his socks and a cloth had to be put under his feet. It took him so long to prepare for a meal that some days he only succeeded in getting one meal. He made the home life intolerable for his sister's family. If anything went wrong he became irritable and excited, finding fault with everyone. He was afraid to read the paper for fear it would cut his eyes. He talked of suicide and expressed the wish that he had the courage to end his misery. Finally one sister attempted to send him to Kings Park State Hospital but the mother would not sign

the commitment papers. During the tentative plans, she made an attempt to secure employment there so she would be near her son. Finally he became so unmanageable, so uneasy and troublesome at night (would shout and scream and have emotional outbreaks) that this made the family seek his commitment. Though the mother made the petition, she was most strongly opposed to his commitment and feels there is no chance for him, and that he came here to die.

When admitted here he was extremely apprehensive and fearful of everyone. At first he refused to go up on the ward saying that he was afraid of men and was afraid of sticking a spoon into his eye. He was afraid to shave for fear he would cut his throat, (wore a full beard on admission), but he finally allowed the barber to shave him. He was seclusive, fearing men too much to mingle with them. He washed for hours at a time. He spent long periods of time at stool. At first he was overproductive in response to questions, but about a week after admission he became more and more evasive, until finally this became a definite though intermittent, stubborn mutism. At first, though, new phobias seemed to develop daily and their nature was imparted to the writer. Some of these innumerable obsessional ideas and phobias were: (1) Fear that he would harm someone, (2) Fear of being poisoned, (3) Fear that he was a "fairy", (4) Fear of all sharp instruments, including pencils, pieces of glass, broken dishes, etc., (5) Fear of writing, (6) Fear of varnish and paint, (7) Fear that the gas would be left turned on, (9) Fear that this was the "bughouse", (10) Fear that he would perform auto-fellatio, or fellatio proper on men whom he met, (11) Fear that he would die of fright, (12) Fear of bathing with other naked men, (13) Fear that he would contract some disease (venereal) from the toilet, etc., etc. There was the constant compulsion to wash his hands and also he spent hours of each day in the toilet for defecation, (anal-erotic satisfaction). There was the delusion that it was necessary to sit at stool until "the white slime comes"—this is a "discharge" given off by "the loins." On further questioning it was learned that "the loins" meant "the testicles" to him. He could not, however, explain how his semen could get into the rectum (this is undoubtedly a pederasty phantasy). He had various suspicions, among them the idea that the other men (patients) were all "testing" him to see if he was a

"fairy," and they watched his trousers all day in order to see if he had an erection, so they could find out his reaction toward the male sex. Also he stated that he walked about with his mouth firmly closed in order to prevent himself from attempting fellatio on other men. He was also fearful that he would attempt to perform fellatio upon himself. On one occasion, during the visit of his mother and sister, he definitely was hallucinated. He imagined he could hear the voice of his dead sister. He said, "I hear L— calling me, saying, I am coming to her. She says, 'Have faith!' 'Have courage!' " He again believed he heard her voice the following day. Both these occurrences were in the writer's presence. Following this he stated that he wanted an opportunity to prove that he had not committed a murder—since he believed that all the men (patients) here were detectives sent to watch him, as he believed there had been a "death" here (probably means an homosexual assault).

Certain passages in his mental trend will serve to illustrate most of the above statements. What fears have you? "Oh, I have all kinds of fears: I'm afraid I'm going to be harmed or am going to harm someone; fear I'm going to be poisoned; not temperate in the normal functions—washing is normal but I wash abnormally; I fear that I'm a fairy." . . . . Why so constipated? "Well, they (bowels) weren't constipated; they moved freely but it doesn't come quickly; its sort of a gripy condition of *the lower end of my bowel*: perhaps here is a good illustration: 'A long-winded movement.' And sometimes I strain and then I see that 'white slime' so I know they are all through moving." . . . . What afraid of most today? "Writing and dishes—go downstairs to eat; and out in the bathroom I'm afraid I'm a 'fairy'; all the men compare me when they take their pants down; and the funny pains in my head; and I don't get much chance to wash my hands here—I've always kept myself so clean." How often wash? "I always washed for every little thing; three times for meals, and every time I went to the bathroom, and any other time I dirty my hands." . . . . What happened to you? "Oh, its awful because I'm afraid all the time I'm going to get my own privates in my mouth and also I'm afraid I'll get other people's in my mouth; when I pass anyone I keep my mouth like this, see!—(shows examiner how closely he holds his lips pursed)—I do this to prevent anything like that happening." . . . . Spontaneously: "But the hardest thing of all was having

to go out there and take a bath naked, with all those other men—*to be in a room with a lot of naked men just increased that fear*—when I'm so afraid of people even clothed." Why worry about that? "Nothing, only 'they' watch my trousers all day to see if my penis is rigid, to see my reaction toward the male sex." Tell something of your early life? "Of course, I don't know whether this is true or imagination, but when I was a kid I put my hand on the privates of a female horse; then I went home and washed my hands; I told my mother about it after my last breakdown." . . . . What else happened during childhood? "Why there was a man about 40, a bachelor, who took an interest in me, and he took me to a number of things—he was very wealthy; and doctors that I tell that to all say that he had improper relations but I don't remember anything of that kind; he used to kiss me good-bye always and one time he game me a bath over at his house; he went around with one boy before he went around with me; and I had a great shock when he broke away from me. My mother thought he wanted to go out with girls. Could a person have improper relations and you not know it? For instance, in your sleep? He took me up to the country with him one whole summer and I slept in the same room with him, and I do know in the mornings he was very affectionate, a great lover; he was very fond of boys." What do you think might have happened? "Well, I don't know, unless, as they say, improper relations—unnatural sexual relations, when a man lies with a man; that's all I know."

The sensorium was practically intact. A few points of interest occurred during this part of examination, however. In reading the "Cowboy Story" for example, he became very fearful and much agitated lest he would not be able to finish the story. He admitted difficulty in thinking, as his mind seemed to become confused quite often. Insight was present at first though only partial. He realized that his fears were only imaginary though he was nevertheless unable to overcome them. He had no insight, however, as to his inherent homosexual cravings. His judgment was very poor.

Physically, there was present marked fibrillation of the skeletal muscles when in a warm place. There was local perspiration of the hands and feet. Touch, pain, heat and cold sensibilities were apparently somewhat diminished. There was some emaciation, more

especially of the face—a factor which accentuated his constant apprehensive expression. Blood Wassermann negative.

Course in hospital: When first admitted he answered questions willingly so that the above trend was secured accurately. He was visited quite frequently (every few days) by his mother and sister. On each of these visits he was petted and pampered, and his delusions of persecution were quite firmly believed to be true facts, by the mother, who continually complained of his ill treatment to the writer. Three weeks after admission, he became completely mute and very resistive to all care. The first appearance of this symptom was on the occasion of a visit by his mother and sister.[4] During the day previous to their visit there had been no change in his condition from that upon admission. But during this visit he became stubborn and partially mute, (it was at this time that he was hallucinated) and the day following he became completely mute, and very unkempt in his appearance (previously tidy). He now refuses to obey commands without assistance and prodding, and will not even walk unless pushed. He makes no voluntary movements and resists those who try to help him. He stares into vacant space as though hearing voices. He has not, however, exhibited catalepsy as yet. He has to be spoon fed and cared for in every way, and he now wets and soils himself.

Diagnosis: He is considered to have been a case of psychoneurosis, psychasthenic type, for a period of many years, showing a marked mother fixation and homosexuality, in whom a regression has now taken place to the state of dementia præcox, catatonic type.

Comment: From his expressed ideas, it is very evident that all his phobias, etc., are of a wish-fulfillment nature, and give plain evidence of the presence of both the oral and anal erotic components of homosexuality. There is also a certain amount of narcissistic or auto-erotic component (as shown by his desire for autofellatio). This of course is also a factor in his oral erotism. Concomitant with his homosexuality, there is also present a marked mother fixation. There is evidence of this both subjectively and objectively. He willingly admits a marked attachment for his mother and his preference for household duties such as sweeping,

4. Kempf described a similar regression to catatonia in one of his cases, which occurred immediately after the patient had a quarrel with her husband who was visiting her at the hospital.

Kempf—The Psychoanalytic Treatment of Dementia Præcox. Psychoanalytic Review, Vol. VI. January, 1919, p. 15.

mopping floor, running the vacuum cleaner, and ironing shows how he sought those duties that would promote his constant association with her. There is plentiful objective evidence in the anamnesis, through which we learn that he was pampered and petted by his mother to a most extreme degree during his entire life. He was also babied by both his sisters continually. Though definite incestuous fantasies are not admitted, it is probable that they may have been present. The patient slept with his mother five years ago (when he was 25) when he became upset following his sister's death, and this even might well have initiated such fancies. A point of interest is the fact that, despite his very evident, though barely conscious homosexual eroticism, he nevertheless showed heterosexual interests in his dreams. He tells of having "wet dreams" quite often, the dream content being that of sexual intercourse with "a woman." One may however postulate the assumption that this in itself is merely further evidence of his pathological mother attachment, since he did not in any single dream recognize the woman with whom he was having coitus—the assumption being that the "woman" was merely a disguised substitute for his own mother whom the censor did not allow him to consciously recognize. The origin of the obsession for washing his hands may be in the conditioned reflex caused by the episode during his childhood, when after playing with the genital organs of a female horse, he went home and most carefully washed his hands.

Case II. M. K. Admitted to Hudson River State Hospital, January 24, 1923, (a transfer from Manhattan State Hospital, where he was admitted August 17, 1916). Male, age 24 on admission (present age 35). Born in Russia, coming to U. S. at the age of one year. Attended common school and also one year of high school; was a bright student. Is Hebrew. Single. Personality: He was always quiet and retiring being considered of a definitely seclusive make-up. Was called a "spoiled child," which would substantiate later evidence of pampering by his mother as shown in his psychosis. It was known that he masturbated excessively during the six months prior to his first admission to Manhattan State Hospital, July 3, 1915. Just previously he was found in the bathtub in his home, in the morning, vomiting and displaying a nervous and apprehensive manner. He was able to return to his work but soon after that he stopped work because of weakness and

hypochondriacal ideas. A doctor examined his eyes about this time, and, patient said afterwards that the doctor had burned his eyes out. He then said that people were "blackmailing" him, and said that people on the street accused him of having "cat's eyes." He became impulsive, broke dishes and threatened suicide by means of a rope he had at one time, and said he would poison himself with some medicine he had. Just prior to admission he took a hatchet and threatened to go to the office of the doctor against whom he had the paranoid delusional trend. He remained in Manhattan State Hospital for five months and was then discharged, but he was readmitted eight months later. During this interval while out of the hospital, he had worked as an usher in a theatre a short time but had had upsets of excitement. Two weeks previous to readmission he had a narrow escape from drowning, when he was badly frightened. On his return home after this happening, he screamed and carried on and finally became so excited that he tried to throw himself out the window.

At the time of his first admission he expressed the paranoid trend against the doctor referred to before, and said he heard people talking about him on the street. Analysis showed a marked homosexual complex as well as incestuous thoughts involving his sister. When readmitted a year later he was restless, noisy and emotionally unstable. He expressed delusional ideas of being poisoned and hallucinations were present. He exhibited mannerisms and grimaces. He improved rapidly at this time and was therefore soon reparoled but returned to the hospital again three months later in an excited, over-active state. This was not unlike a manic attack. Since that time he has remained in State hospitals, showing various symptoms. In 1920 he was quiet, working on the Manhattan State Hospital farm, but was subject to auditory hallucinations without insight. In October, 1922, he was unimproved, still showing mannerisms and was actively hallucinated. He would weep, then soon after would be smiling and laughing and talking to himself. In February, 1924, he stated he could read thoughts of others, and he had delusions of electricity running through his body. In August, 1924, he became disturbed and he was subject to marked persecutory delusions, saying he was accused of stealing diamonds and that he was beaten up. He said that his enemies were all as crazy as he was. He said at that time, "At times I believe I am married, but I

am not married today as I can't be married until I live with a woman nine months and have a child" (showing fear of his own impotence problably).

He has continued in much the same condition up to the present time. An attempt will be made to classify the various delusional ideas which he now has into groups, i. e., homosexual, incestuous, auto-erotic and heterosexual ideas. Naturally some of the ideas placed in one classification will be partly classifiable in one or more of the other groups, but it is hoped that this division will clarify the case to some extent.

Homosexual trend: He states: "*People* are bothering me here (points to genitalia) they are kicking me in the penis and one of them called me a c. s., and I never did that in my life (here he tried to defend himself against his own unconscious homosexual cravings). I'm not a thief, crook or criminal—when I go to bed people come to my bed and smash me in the eyes (probably a distorted fantasy of an homosexual assault)—and I hear voices talking to me—all strangers—*they* tell me I'm a c. s., but I ain't no c. s.—am I a c. s. Doctor? No, I never was a c. s. in my life—they want to f— (slang word for intercourse), they want to screw—everybody wants to be happy. A lot of strangers beat me up (homosexual assault) —*they* are men, women and children, but I ain't seen no women around here—what's the idea of striking me in the eyes and making me blind—*they* hit me in the eyes with knives, guns and bullets (phallic symbols)." When asked about fellatio he says: "Why I wouldn't call them c. s., though *they* are 'toucher-ups'—*they* put their hands on my p— (genital) and also my ears—*they* are strangers—*they* overpower me, tear my stockings, shoes and clothing—*they* want to fight me—maybe they want to kill me for my money. *They* call me bum, yes bum. Oh! s. o. b. of a Jew—go on you dirty s. o. b. I never called anybody any such names—M. K., that's my name—do I need medicine if I have a bad odor in my mouth (he is probably here having a fantasy of the bad taste in his mouth following the ecstasy and excitement of his fellatio fantasies). He expectorates continually, evidently to get rid of the undesirable substances (delusional semen) in his mouth. On one occasion he said: "*They* throw dirt and filth in my meals and make me eat it."

Œdipus complex—incestuous trend: He expresses many grandiose delusions, in his effort to assume the role of the father in his

phantasies. He says: "Well are you a doctor—I'm a doctor, too; Dr. K— (father surrogate). I got the message last night sent me by Western Union through Cal. Coolidge—*they* told me my mother died and they buried her in M—L. I. She died in 1907—she's living though—*they* put life into her—I saw her walk in here." A definite fantasy of incest is present, i. e. "She (his mother) is very beautiful—she has wonderful clothes—she is L. B. K. and their real family name is Christopher Mathewson—Oh! Yes—*they* told me very politely to f— my mother—*they* spoke to me very roughly—*they* drove me to insanity. This shows well the resistance consciously developed against the suggestion of incestuous cravings); *they* got dual personalities." Again the delusions of grandeur. "M. K., that's my name—I'm the greatest gentleman in the entire universe today, for ever and ever—I'm God Almighty—that's what I am."

Autoerotic trend: Along these lines he says: "*They* call me a masturbator—*they* masturbate themselves, but when they see a person like me who don't masturbate *they* want to kill me." This statement is of interest in view of the fact that he repeatedly does masturbate on the ward. He later said: "In some way *they* make me masturbate myself and I question whether I should do this."

Heterosexual trend: Of the many statements he makes, a large number would appear to be on an heterosexual level, but the writer believes that most of this material is thrown into his stream of talk as a sort of veneer to attempt to cover over his stronger homosexual cravings, through a description of his imagined heterosexual virility. He probably has never fully attained the actual heterosexual level of development, and his many statements as to his virility are in all probability merely compensatory delusions of grandeur conjured up to satisfy the inferiority complex caused by his actual heterosexual impotency. He says: "I took a girl out one night—she got me crazy—she kissed me and said she loved me—but I got a spell—people were choking me and laughing at me (showing his inability to meet the exigencies of heterosexual love)." Then he boastfully states: "Of course I've seen a lot of females and I am naturally passionate—I fell in love with a girl in P— and asked her for intercourse, and I have 'cat's eyes;' they have hypnotic

effects[5]—and they gave me anaphylaxis treatment in New York." Again later. "They (girls) are crazy for intercouse; they call me a masturbator—there are voices talking to me; males and females, crazy ones; I guess *they* want intercourse; they talk to me in a slangy language; *they* want to 'murder' (sexually assault) me, and others too; *they* talk irrationally; *they* are very pugnacious and *they* attacked me and should be punished, Doctor." There are however certain doubts in his own mind as to his heterosexual potency, as evidenced by the following: "I tell you I need—(intercourse) once in a while—do you think I could have relations with a female?" He then describes in detail a certain time when he had sexual relations with a certain girl in New York. It was evident from his description that he was partially impotent in the relation, though he attempts to explain this as a frigidity on her part—through a mechanism of projection. In order to compensate for this fear of his own impotence, he said: "All the girls want to get married to me; they are all crazy to have me; they want to get pregnant by me." This is probably a compensatory delusional idea of grandeur due to his actual heterosexual impotency.

The serology was entirely negative. The diagnosis in the case was dementia præcox, paranoid type.

Comment: This man undoubtedly received a great amount of libidinous satisfaction through the means of the many fantasies of orgies of homosexual practices which he is constantly harboring. He is thus able to satisfy those perverse cravings which he could not allow himself to satisfy in the gross homosexual manner, because of the conscious censorship of his personal ideals. Thus, when he is "overpowered by strange men," or "killed (sexually assaulted) or "murdered," by men, he is in his imagination, receiving the satisfaction he might receive in an actual homosexual relation. In a similar manner, when in his fantasies he is directed by imaginary persons to have intercourse with his mother, he is unconsciously allowing himself the satisfaction of those perverse cravings which

5. It is quite possible that there is a definite symbolic meaning to this. Cats are said to be able to hypnotize snakes merely by the use of their eyes, thereby being able to do as they wish with the snake. He may well mean therefore that he can hypnotize "snakes" (well known phallic symbol). It does not require very much imagination to realize for what purpose he would use his "hypnotized snake" when one thinks of his strong homosexual tendencies.

he consciously regards as taboo, asocial and absolutely contrary to his ideals.

The psychosis is in itself the means of satisfaction or mode of expression of homosexual or other perverse cravings, in those who cannot make their perverse cravings compatible with their conscious ideals as to the proper method of pursuing their sexual life. Thus it is the conflict between conscious ideals and perverse cravings that results in the psychosis.

Conclusions

1. In most cases of schizophrenia, the combination of homosexual and incestuous cravings can be shown to exist.
2. The psychosis can be shown to express a conflict between these perverse cravings and the conscious ideals of the individual.
3. It is quite probable that in the inaccessible cases of schizophrenia, these same forces are operative in the psychosis.
4. It is apparently the introverted personality of the individual that favors the development of the homosexual and incestuous tendencies, because of the greater difficulty in adjusting to heterosexual contacts.

EDUCATIONAL WORK OF THE STATE HOSPITAL

BY HARRY A. STECKEL, M. D.,

DIRECTOR OF CLINICAL PSYCHIATRY, BINGHAMTON STATE HOSPITAL

Any comprehensive and effective program directed toward the prevention of mental disorder must include a system of education, whereby the public may become informed regarding the fundamental principles of mental hygiene.

It seems clear to us that if anything is to be accomplished in the matter of reducing the incidence of mental disorders the laity must have at least a superficial knowledge of what our present day conceptions of "mental illness" are; must know what we believe are the fundamental causes; and must be able to detect premonitory symptoms manifesting themselves often many years before they noticeably interfere with an individual's efficiency.

We doubt if any one who has given this matter any amount of thought and study would fail to agree with us, if we declared that education is really the foundation upon which must rest any concerted effort to combat this spectre which appears to be an ever increasing menace to the human family.

The questions which confront us are: How may we get the facts before the people in an enlightening as well as an interesting fashion, and upon whom should the duty of this educational program fall?

We recognize the fact that for centuries the subject of mental disorder has been veiled in a shroud of mystery and superstition, which even today causes a large majority of people to avoid even the mention of mental aberration. It is time this veil was lifted. For many years a barrier has imposed itself between the public and the institutions for the mentally disordered. It would seem to us that the fabric of this barrier comprises not only the medieval superstitions of the public regarding the matter, but also contained in its composition material which arose on a basis of ignorance on the part of the personnel of these institutions, which made them loath to discuss something about which they should know much yet knew so little.

With our present knowledge of psychopathology there is no need for this barrier; and it must come down. Let us therefore, through

knowledge dispel superstition, and what better agents for disseminating information could we hope for than those who have daily contact with the mentally disordered, and whose entire lives are devoted to the study and relief of those unfortunates in whom the light of understanding has gone out. We refer to the physicians of our State hospitals.

Each institution should constitute itself an educational center for the district which it serves; speakers' bureaus comprising members of the medical staff should be established, and the public made aware that the services of the speakers are always available. It may be argued by some that should a scheme of this nature prevail the work of the hospital would suffer, as members of the medical staff can ill be spared for work of this kind. It is true that added effort is required for work of this kind, but we feel it is worth the effort both to the hospital, to the public, and to the staff.

The hospital and the public are benefited by the rapport so established, and the members of the staff by the extramural contacts so made and attainable in no other way. Furthermore, the desire of the members of the speakers' bureau to acquire knowledge sufficiently well to impart it to others, which such work naturally stimulates, tends to enhance the value of the staff to the hospital in a remarkable degree.

Assuming that all the foregoing statements are true; upon whom shall we inflict the services of this group of educators? If our present understanding is correct, that more than 50 per cent of all mental disorders are due to personality defects, the foundation for which were laid in early childhood, then the two outstanding groups to be attacked are parents and teachers. Almost any group of adults would therefore be eligible, as a large majority of them would answer to the name of "Father" or "Mother." Every community large or small has certain social or civic organizations, who are always anxious to obtain speakers to address their meetings, for example; service clubs, church organizations, women's clubs, etc. Parent-teacher associations are particularly good leads, as here we meet both the groups in greatest need for education along mental hygiene lines. Teachers may be reached also through short talks on mental hygiene, delivered at annual institutes, to teacher-training classes in the county schools, classes in the normal schools, and through college extension courses, such as are avail-

able in many of the larger cities. It is surprising too how eager all the above mentioned groups are for this work.

Social worker groups should also be approached. Certainly delinquency, prostitution, dependency, etc., have mental elements in their etiology, and at least a psychiatric viewpoint is essential to any worker whose duty it is to assist individuals in adjusting to their environment.

Many of our hospitals have within their districts colleges or educational institutions of various kinds. Classes in normal or abnormal psychology or in sociology are often benefited by a presentation of clinic material, with a discussion of the psychopathology of the benign as well as malignant psychoses. The services of the hospital for such classes should be made available, as many members of college groups are destined to become parents, some teachers, others social workers, so that here we are able to reach the various individuals most concerned.

Few hospital districts there are in which there are no general hospitals with nurses' training classes. Such hospitals are always anxious to secure the services of State hospital physicians to give courses in psychiatry, and it seems to us that here is one of our greatest opportunities to further this important work of prevention.

We have purposely neglected to mention the matter of post-graduate instruction in psychiatry to groups of physicians. Where requests for such courses are made, the hospital should naturally supply instructors. The value of work with the profession, so far as prevention is concerned, is not of such great moment as behavior problems indicating incipient mental disorders so seldom come to the physician for relief. Our experience would indicate that for the present at least our contacts with the profession should be confined to active membership, and participation in the program of various medical societies with occasional joint meetings of such societies with our own psychiatric societies, of which there should be one in each State hospital.

The value of distributing literature on the various phases of mental hygiene should be mentioned. Leaflets recently distributed by the Department of Mental Hygiene, are excellent and may be supplemented by others obtainable from the State Charities Aid Association, or The National Committee for Mental Hygiene, etc.

The out-patient clinics naturally serve in an educational capacity,

but of course fail to meet sufficiently large groups of people. Clinics may serve, however, as an adjunct in the educational work in an indirect manner. Practically all hospital clinics are heralded through the local newspapers. If to the paragraphs announcing the clinic be added several paragraphs touching in an interesting and understandable fashion upon some special phase of mental hygiene, our message may be made to reach many individuals who would otherwise fail to grasp the import and purpose of our work. Suggestions for such announcements could be offered by the Department of Mental Hygiene through the Division of Prevention, so that there might be uniformity in the manner in which publicity is handled.

This then, briefly outlines what we believe to be an adequate educational program, and one which may be carried out by any State hospital with little added effort. It is needless to say that forceful and pleasing speakers are essential, and we believe large numbers of such speakers may be developed from our medical personnel, if they are given the necessary encouragement and opportunity.

The subject matter of the lectures, and the methods of approach will vary with the character of the audience. We have from past experience formulated some ideas upon this phase of the subject, but as a discussion of this matter will require more space than is now available we will not touch upon it here.

The educational program outlined above has been carried out by the Binghamton State Hospital since the fall of 1924, and as a result of this work there has been an appreciable increase in the number of patients with incipient mental disorders coming to the out-patient clinics, and it is believed that a considerable number of these have been prevented from developing definite psychoses, and therefore requiring hospitalization. Furthermore, we believe that because of the better understanding on the part of the public of the purpose of the clinics, definite psychoses are earlier recognized, hospitalization afforded sooner, and the period of the psychosis much reduced. This, of course, is only our impression as it is too early yet to prove this impression by statistics.

It is interesting to note the steady increase in the number of visits to our out-patient clinics which has occurred since the beginning of our educational program. The monthly average of new cases

attending the clinics was 12.4 in 1924, 18.1 in 1925, 21.75 in 1926, and 44 in the first eight months of 1927. If, as we believe the clinic attendance is an indication of the amount of preventive work that we are able to accomplish, it seems to us these figures are quite suggestive of the value of our educational campaign in the matter of prevention.

It is hoped that what we have set forth here may stimulate others in this most important field of public education in the principles of mental hygiene, and that they may find something of value in the suggestions offered.

STATE INSTITUTION POPULATION STILL INCREASING

BY HORATIO M. POLLOCK, PH. D.,
DIRECTOR, STATISTICAL BUREAU, STATE DEPARTMENT OF MENTAL HYGIENE

The preliminary results of the first annual census of State institutions taken by the Federal Census Bureau were made available for publication early in October, 1927. The census included state hospitals for mental disease, state institutions for the feebleminded and state prisons and reformatories. The report sent out by the Census Bureau gives data for each class of institutions relative to resident population on January 1, 1927, and to admissions during the calendar year of 1926.

The report concerning patients with mental disease covers 30 states; the one concerning feebleminded and epileptics, 36 states; and the one concerning prisoners, 31 states. As comparisons are made with the results in the same states shown by the 1923 census the trend in institution population is clearly indicated. A striking feature of the report is the marked increase in the population of all three classes of state institutions, the rate of increase far exceeding that of the general population. Either the number of social deviates is increasing or the people to a greater extent are turning to state institutions for relief. The latter explanation seems the more probable; but, whatever the reason, it is clear that the burden of mental disease, mental defect and crime borne by the state is continually becoming heavier.

Increase of Patients in Hospitals for Mental Disease

RESIDENT PATIENTS

The resident patients in 105 state hospitals for mental disease in the 30 states for which complete returns were received numbered 178,353 on January 1, 1927, as compared with 161,566 on January 1, 1923. The rate of patients per 100,000 of population in these states shown by the 1927 census was 226.9 and by the 1923 census 218.5. The results in the several states for the two census dates are given in Table I.

It will be noted from the comparisons in Table 1, that an increase in the number of resident patients occurred between 1923 and 1927 in every state listed in the table except Oregon, and that an increase in the rate of patients per 100,000 of population was found

TABLE 1—PATIENTS IN STATE HOSPITALS FOR MENTAL DISEASES, 1927 AND 1923

Division and State	Jan. 1 1927	Jan. 1 1923	Number per 100,000 of general population*	
			1927	1923
Total—30 states	178,353	161,566	226.9	218.5
New England:				
Maine	1,918	1,838	242.5	236.2
New Hampshire	1,560	1,399	343.6	312.3
Vermont	835	784	236.9	222.5
Rhode Island	1,735	1,485	248.2	229.5
Middle Atlantic:				
New York	43,538	39,510	383.1	365.3
Pennsylvania	12,118	10,545	125.3	115.7
East North Central:				
Ohio	13,844	12,811	208.0	209.1
Indiana	6,441	5,780	205.3	191.7
Illinois	20,317	18,764	280.2	275.9
Michigan	7,765	7,392	174.8	185.4
West North Central:				
Iowa	5,346	5,002	220.5	207.2
Missouri	5,706	5,242	162.8	152.2
North Dakota	1,400	1,269	218.3	197.0
South Dakota	1,317	1,207	190.0	182.3
Kansas	3,697	3,295	202.7	183.6
South Atlantic:				
Delaware	575	518	238.6	224.2
District of Columbia	4,326	3,931	810.1	824.1
West Virginia	2,315	2,134	137.6	137.3
South Carolina	2,558	2,400	139.4	137.5
Georgia	4,848	3,972	153.7	132.3
Florida	2,585	1,950	192.9	170.9
East South Central:				
Kentucky	4,831	4,635	190.9	188.1
Mississippi	2,855	2,537	159.4	141.7
West South Central:				
Louisiana	3,458	3,022	179.5	163.3
Oklahoma	3,566	2,873	150.9	132.6
Mountain:				
Colorado	2,324	2,017	218.0	203.3
Arizona	684	554	151.3	145.0
Utah	781	697	150.8	145.8
Pacific:				
Oregon	2,019	2,406	228.4	291.6
California	12,998	11,507	297.1	301.5
Federal**	93	90	....	....

* Based on the estimated population for January 1.

** Federal "Asylum for Insane Indians," Canton, South Dakota.

in all these states except Ohio, Michigan, Oregon and California. A decline in rate also occurred in the District of Columbia.

The highest rate of resident patients per 100,000 of population in 1927 (383.1), was found in New York, and the lowest rate (125.3), in Pennsylvania. The low rate in the latter state is due in part to the fact that a considerable proportion of the patients with mental diseases are cared for in county institutions which are not included in this census. The rates in the several states as a rule indicate the extent of the provision made for the care of mental patients.

FIRST ADMISSIONS

The census of first admissions covers the year 1926 and the results are compared with those of the census of first admissions of 1922. During this period of four years the first admissions to state hospitals in the 30 states increased from 34,362 to 36,936 and the rate per 100,000 from 46.8 to 47.3. The results for the several states are shown in Table 2.

Increases in rates of first admissions are found in 16 states and decreases in rates in the District of Columbia and 13 states. The wide variations in the several states are not fully accountable. Four states and the District of Columbia in 1926 had rates above 70 per 100,000 and eight states had rates under 35. Such a wide divergence in rates would indicate that state hospitals are used for the care of mental patients to a much greater degree in some states than in others. The actual difference in rates of incidence of mental disease is probably much less than these figures would indicate.

It is gratifying that the general rate of increase of first admissions is so low. Judging from the experience of New York during the past nine months the rate of increase in 1927 will be accelerated.

Census of Institutions for Feebleminded and Epileptics

RESIDENT PATIENTS

The complete returns received by the Census Bureau from the institutions for feebleminded and epileptics in 36 states show that the resident patient population of these institutions had increased from 42,164 on January 1, 1923, to 52,043 on January 1, 1927. The rate per 100,000 of population had increased from 47.0 to 54.7. These rates throw no light on the relative increase of feeblemindedness and epilepsy in the several states in the two years, but are sig-

TBALE 2—FIRST ADMISSIONS TO STATE HOSPITALS FOR MENTAL DISEASE, 1926 AND 1922

Division and State	Number of institutions 1926	First admissions during the year			
		1926	1922	Number per 100,000 of general population*	
				1926	1922
Total—30 states	105	36,936	34,362	47.3	46.8
New England::					
Maine	2	371	339	47.0	43.7
New Hampshire	1	375	306	82.6	68.5
Vermont	1	160	164	45.4	46.5
Rhode Island	1	391	346	56.4	54.1
Middle Atlantic:					
New York	16	7,711	7,218	68.2	67.2
Pennsylvania	9	2,092	1,525	21.8	16.9
East North Central:					
Ohio	8	3,215	2,708	48.7	44.7
Indiana	6	1,231	955	39.4	31.8
Illinois	10	4,352	5,053	60.4	74.9
Michigan	5	1,313	1,236	29.9	31.5
West North Central:					
Iowa	5	922	939	38.1	38.9
Missouri	4	1,209	1,139	34.6	33.1
North Dakota	1	236	242	36.8	37.6
South Dakota	1	201	168	29.2	25.5
Kansas	4	677	632	37.2	35.3
South Atlantic:					
Delaware	1	163	96	67.9	41.9
District of Columbia	1	641	888	121.4	188.9
West Virginia	4	725	687	43.4	44.7
South Carolina	1	601	643	32.9	37.1
Georgia	1	954	652	30.4	21.9
Florida	1	1,024	688	77.8	61.9
East South Central:					
Kentucky	3	1,161	1,169	46.0	47.6
Mississippi	2	1,008	922	56.3	51.5
West South Central:					
Louisiana	2	592	547	30.8	29.7
Oklahoma	3	1,078	695	46.0	32.5
Mountain:					
Colorado	1	377	399	35.6	40.6
Arizona	1	169	209	38.0	55.9
Utah	1	173	183	33.7	38.7
Pacific:					
Oregon	2	686	709	78.2	86.8
California	6	3,121	2,891	72.3	77.2
Federal**	1	7	14	...	...

* Based on the estimated population for July 1.

** Federal "Asylum for Insane Indians," Canton, South Dakota.

TABLE 3—RESIDENT PATIENTS IN STATE INSTITUTIONS FOR FEEBLEMINDED AND EPILEPTICS, 1927 AND 1923

Division and State	Jan. 1 1927	Jan. 1 1923	Number per 100,000 of general population*	
			1927	1923
Total—36 states	52,043	42,164	54.7	47.0
New England:				
Maine	669	467	84.6	60.0
New Hampshire	425	393	93.6	87.7
Vermont	234	179	66.4	50.8
Massachusetts	5,092	4,062	120.7	101.1
Rhode Island	426	377	60.9	58.3
Connecticut	634	555	39.1	37.5
Middle Atlantic:				
New York	8,682	7,239	76.4	66.9
Pennsylvania	3,542	3,372	36.6	37.0
East North Central:				
Ohio	5,335	4,229	80.2	69.0
Indiana	2,412	1,945	76.9	64.5
Illinois	3,931	2,625	54.2	38.6
Michigan	3,344	2,688	75.3	67.4
Wisconsin	1,299	1,227	44.8	44.7
West North Central:				
Minnesota	2,002	1,857	75.0	74.2
Iowa	2,283	1,964	94.2	81.4
Missouri	713	587	20.3	17.0
North Dakota	517	338	80.6	52.5
South Dakota	428	424	61.8	64.0
Nebraska	845	751	60.8	56.3
Kansas	1,387	1,300	76.0	72.4
South Atlantic:				
Delaware	104	50	43.2	21.6
District of Columbia	41	**	7.7	**
Virginia	772	533	30.5	22.2
West Virginia	748	547	44.4	35.2
South Carolina	334	123	18.2	7.0
Georgia	71	44	2.3	1.5
Florida	299	140	22.3	12.3
East South Central:				
Kentucky	456	425	18.0	17.2
Alabama	287	**	11.5	**
Mississippi	125	72	7.0	4.0
West South Central:				
Louisiana	231	130	12.0	7.0
Mountain:				
Idaho	285	253	54.0	53.7
Colorado	332	255	31.1	25.7
Pacific:				
Washington	900	803	58.1	55.9
Oregon	797	675	90.2	81.8
California	2,061	1,535	47.1	40.2

* Based on the estimated population for January 1. ** Not in operation January 1, 1923.

nificant in indicating the trend of the institution population of these classes. It is regrettable that the preliminary report does not report the feebleminded and epileptics separately.

Table 3 shows that the resident patients of these classes increased during the four-year period in each of the states listed, although the increase in several states was very slight. The rates of patients under care vary from 7.0 in Mississippi to 120.7 in Massachusetts. As a rule the rates are much higher in the northern than in the southern states.

FIRST ADMISSIONS WITH MENTAL DEFECT OR EPILEPSY

The first admissions to the state institutions for feebleminded and epileptics in 1926 in the 36 states numbered 7,203 as compared with 6,633 in 1922. The rate per 100,000 of population increased during the period from 7.4 to 7.6, too little to be significant in indicating a trend.

Notwithstanding the increase in resident patients observed above in every state listed in Table 3, Table 4 shows in several states a marked falling off of first admissions in 1926 as compared with 1922. The reason for the decline is probably found in the crowded condition of the institutions, rather than in the scarcity of patients seeking admission. Were suitable institutions available, the rate of first admissions with mental defect would undoubtedly be much greater.

CENSUS OF PRISONS AND REFORMATORIES

Complete census returns from the state prisons and reformatories of 31 states show that the inmate resident population increased from 47,578 on January 1, 1923, to 63,828 on January 1, 1927. The rate per 100,000 of population increased from 66.6 to 84.1. This enormous increase probably reflects a more active enforcement of law and a greater severity of sentence rather than an increase in crime. In the absence of satisfactory data concerning crime, however, no positive conclusions can be drawn.

Table 5 shows that in all but 7 of the 31 states listed the rate of resident prisoners had increased from 1923 to 1927. In Ohio and Kansas the rate nearly doubled. Other states with exceptionally

TABLE 4—FIRST ADMISSIONS TO STATE INSTITUTIONS FOR FEEBLEMINDED AND EPILEPTICS 1926 AND 1922

Division and State	Number of institutions 1926	First admissions during the year			
		1926	1922	Number per 100,000 of general population*	
				1926	1922
Total—36 states	60	7,203	6,633	7.6	7.4
New England:					
Maine	1	71	104	9.0	13.4
New Hampshire	1	50	38	11.0	8.5
Vermont	1	22	55	6.2	15.6
Massachusetts	5	500	483	11.9	12.1
Rhode Island	1	72	36	10.4	5.6
Connecticut	1	80	39	5.0	2.7
Middle Atlantic:					
New York	7	1,092	1,424	9.7	13.3
Pennsylvania	3	348	310	3.6	3.4
East North Central:					
Ohio	3	957	520	14.5	8.6
Indiana	3	333	226	10.7	7.5
Illinois	2	743	423	10.3	6.3
Michigan	2	533	659	12.1	16.8
Wisconsin	2	203	236	7.0	8.7
West North Central:					
Minnesota	2	212	197	8.0	7.9
Iowa	2	179	239	7.4	9.9
Missouri	1	62	37	1.8	1.1
North Dakota	1	104	31	16.2	4.8
South Dakota	1	47	79	6.8	12.0
Nebraska	1	85	91	6.1	6.9
Kansas	2	186	151	10.2	8.4
South Atlantic:					
Delaware	1	11	24	4.6	10.5
District of Columbia	1	7	**	1.3	**
Virginia	1	115	75	4.6	3.1
West Virginia	1	153	119	9.2	7.7
South Carolina	1	39	23	2.1	1.3
Georgia	1	18	9	0.6	0.3
Florida	1	123	133	9.3	12.0
East South Central:					
Kentucky	1	29	22	1.2	0.9
Alabama	1	34	**	1.4	**
Mississippi	1	14	13	0.8	0.7
West South Central:					
Louisiana	1	54	99	2.8	5.4
Mountain:					
Idaho	1	22	58	4.2	12.5
Colorado	2	39	48	3.7	4.9
Pacific:					
Washington	1	140	165	9.1	11.6
Oregon	1	131	162	14.9	19.8
California	2	395	305	9.2	8.1

* Based on the estimated population for July 1. ** Not in operation in 1922.

TABLE 5—PRISONERS IN STATE PRISONS AND REFORMATORIES, 1927 AND 1923

Division and State	Jan. 1 1927	Jan. 1 1923	Number per 100,000 of general population*	
			1927	1923
Total—31 states	63,828	47,578	84.1	66.6
New England:				
New Hampshire	133	138	29.3	30.8
Massachusetts	1,923	1,448	45.6	36.0
Rhode Island	**388	355	**55.5	54.9
Middle Atlantic:				
Pennsylvania	4,170	4,298	43.1	47.2
East North Central:				
Ohio	9,144	4,234	137.4	69.1
Illinois	6,368	4,416	87.8	64.9
Wisconsin	1,521	1,158	52.4	42.2
West North Central::				
Minnesota	2,371	1,634	88.8	65.3
Iowa	2,144	1,794	88.4	74.3
Missouri	3,442	2,205	98.2	64.0
North Dakota	309	244	48.2	37.9
South Dakota	494	326	71.3	49.2
Nebraska	998	789	71.8	59.1
Kansas	2,968	1,574	162.7	87.7
South Atlantic:				
Virginia	1,979	1,960	78.2	81.6
West Virginia	1,799	1,628	106.9	104.8
North Carolina	1,580	1,046	54.9	38.9
East South Central:				
Kentucky	2,248	2,079	88.8	84.4
Mississippi	1,564	1,620	87.3	90.5
West South Central:				
Louisiana	1,682	1,593	87.3	86.1
Oklahoma	2,681	1,799	113.5	83.1
Texas	3,225	3,577	60.2	72.3
Mountain:				
Montana	437	331	62.0	54.0
Wyoming	264	335	110.9	157.3
Colorado	1,129	1,015	105.9	102.3
Arizona	444	355	98.2	92.9
Utah	210	200	40.5	41.8
Nevada	231	174	298.4	224.8
Pacific:				
Washington	1,548	1,010	99.9	70.3
Oregon	572	406	64.7	49.2
California	5,862	3,837	134.0	100.5

* Based on the estimated population for January 1.

** Includes data for the Rhode Island State Reformatory for Women, which has been established since 1923.

high rates are West Virginia, Oklahoma, Wyoming, Colorado, Nevada and California.

Unfortunately, data from New York State are lacking.

The social import of the present wave of severe penalties for crime cannot at present be judged. By many, it is regarded as a movement in the wrong direction, by others, it is believed to be the only way of adequately protecting society.

Admissions to State Prisons and Reformatories

In collecting data concerning prisoners admitted to state penal institutions it has not been found practicable to separate first admissions from readmissions. It is probable that a large majority of the admissions reported in Table 6 are not without previous record of crime. Many have served other sentences in state prison and others have been previously in jails and other minor penal institutions. The admissions represented by these statistics are the post-graduates, so to speak, of the school of crime.

Table 6 compares the admissions to state prisons and reformatories of 1926 and 1923 in 31 states. The increase in number during that period was from 21,054 to 27,018, and in rate per 100,000 of population from 27.9 to 34.1. It is noteworthy that the rate of admissions increased in all but 5 of the 31 states.

The rates in the several states vary from 158.9 in Nevada to 7.3 in New Hampshire. The rates are influenced by many factors and cannot be considered an index of the extent of crime in the various states. It is quite possible that a high rate of admissions might be found in a state having less than the average rate of crime. Laxity in the enforcement of law while producing a low admission rate, encourages criminals to pursue their nefarious work.

The Federal Census Bureau by collecting and presenting these annual statistics of institution population is rendering a valuable service to state administrators and to all engaged in ameliorative work.

TABLE 6—ADMISSIONS TO STATE PRISONS AND REFORMATORIES, 1926 AND 1923

Division and State	Number of institutions 1926	Prisoners received from courts during the year			
		1926	1923	Number per 100,000 of general population*	
				1926	1923
Total—31 states	58	27,018	21,054	34.1	27.9
New England:					
New Hampshire	1	33	35	7.3	7.8
Massachusetts	3	818	693	19.5	17.1
Rhode Island	2	**197	57	**28.4	8.7
Middle Atlantic:					
Pennsylvania	4	1,531	1,256	15.9	13.7
East North Central:					
Ohio	4	3,171	2,264	48.0	36.6
Illinois	4	1,726	1,387	24.0	20.2
Wisconsin	3	819	532	28.4	19.3
West North Central:					
Minnesota	3	822	659	31.0	26.1
Iowa	3	677	753	27.9	31.2
Missouri	1	1,609	912	46.0	26.4
North Dakota	1	210	136	32.8	21.2
South Dakota	1	296	185	43.0	27.8
Nebraska	3	495	378	35.7	28.2
Kansas	3	1,256	1,001	69.0	55.6
South Atlantic:					
Virginia	1	844	608	33.5	25.1
West Virginia	1	850	772	50.9	49.2
North Carolina	1	580	368	20.3	13.6
East South Central:					
Kentucky	2	1,365	827	54.1	33.5
Mississippi	1	649	478	36.2	26.7
West South Central:					
Louisiana	1	765	559	39.9	30.0
Oklahoma	2	1,683	1,711	71.9	78.1
Texas	1	1,979	1,503	37.2	30.1
Mountain:					
Montana	1	277	243	39.9	38.9
Wyoming	1	76	125	32.2	57.9
Colorado	2	806	562	76.1	56.1
Arizona	1	256	207	57.5	52.9
Utah	1	157	186	30.5	38.5
Nevada	1	123	75	158.9	96.9
Pacific:					
Washington	2	827	750	53.8	51.7
Oregon	1	332	262	37.9	31.5
California	2	1,789	1,570	41.5	40.4

* Based on the estimated population for July 1.

** Includes data for the Rhode Island State Reformatory for Women, which has been established since 1923.

BOOK REVIEWS

Transfusion of Blood. By HENRY M. FEINBLATT, M. D., Assistant Clinical Professor of Medicine, The Long Island College Hospital, Brooklyn, N. Y. The Macmillan Company, New York.

In this small volume of 133 pages Dr. Feinblatt has presented a critical survey of the subject of blood transfusion as it stands today and has arranged the text so that each chapter becomes a ready reference on the several phases of the subject.

He shows how the discovery of iso-agglutinins and iso-agglutinable substances by Landsteiner and Shattock in 1900 stimulated the general use of blood transfusion, already developed by Crile's practicable method of direct transfusion in 1907.

In Chapter 1, he gives a historical resume of the steps in the development of the modern practice and cites the use of syringes, paraffin-coated containers, etc., and a method of indirect transfusion using a glucose and sodium citrate solution as an anticoagulant, elaborated by Lewisohn.

Certain problems relating to blood transfusion he considers are of sufficient importance to warrant separate consideration so individual chapters are allotted to the blood groups (Chapter 3), blood donors (Chapter 4), the indications for blood transfusion (Chapter 5) and the untoward results from transfusion (Chapter 6).

In Chapter 2 he states that our knowledge of the physiologic factors entering into the subject are still somewhat fragmentary although the technique has attained a considerable degree of perfection and the indications and contraindications for the operation have been fairly well defined.

Blood clotting being one of the chief obstacles he shows how it is overcome in one of four ways, namely: 1. By rapidity of manipulation; 2. By the reception of the blood through a strictly clean and smooth cannula, coated with a layer of paraffin or vaseline, into a vessel similarly coated; 3. By defibrination, and 4. By the addition of anticoagulants.

Transfusion accomplishes good in three chief ways:

1. It fills the vessels with a viscous medium, which is retained in the vascular tree with more favorable results than when solutions containing only crystalloid bodies are injected.

2. It adds a considerable number of oxygen carriers, noticeable immediately in the recipient by an improvement in color due to the addition of a large number of red cells.

3. It furnishes a powerful hemapoietic stimulus, not so much by directly stimulating the hematogenic areas as acting in the role of a hematinic by breaking a vicious circle.

In Chapter 3 on the classifications of blood groups he uses that of Jansky and according to the possible combinations of the iso-aggglutinins A and B and of the iso-agglutinogens a and b he divides them into four groups:

Group 1. Plasma contains iso-agglutinins A and B.
Corpuscles contain neither iso-agglutinogen.

Group 2. Plasma contains iso-agglutinin A.
Corpuscles contain iso-agglutinogen b.

Group 3. Plasma contains iso-agglutinin B.
Corpuscles contain iso-agglutinogen a.

Group 4. Plasmas contains neither iso-agglutinin.
Corpuscles contain iso-agglutinogens a and b.

He then goes on to show the method of determining the blood groups and explains certain sources of error in blood matching.

In Chapter 4, he considers the principal factors entering into the choice of a donor under various headings, some of which are: Age, sex, blood group, freedom from communicable disease, etc.

In Chapter 5, the author enumerates the indications for blood transfusion, emphasizing its early use in the control of hemorrhage, its great value in the treatment of surgical shock, illuminating gas poisoning, etc.

In discussing the indications for its use in pernicious anemia he gives some laboratory findings with records of clinical cases.

Chapter 6 deals with the dangers and ill effects from transfusion, where he takes up the possibility of massive agglutination and hemolysis of the cells, an anaphylactic reaction and the transmission of communicable diseases. Clinical pictures of these unfavorable reactions are shown in clear and convincing words.

Chapters 7 and 8 take up the methods of performing the operation of blood transfusion and are well illustrated by actual photographs of instruments and by schematic drawings.

The last two chapters are devoted to transfusion in children and auto and exsanguination transfusion.

Appended to each chapter is a well chosen bibliography indicating that the author has made an extensive survey of the literature.

The author's method of presenting his subject is clear and concise, the print is large and easy to read. Altogether the book is worthwhile and should be a valuable addition to the library of the clinician as well as to that of the surgeon.

GRAY.

Obstetrics for Nurses. By JOSEPH B. DELEE, A. M., M. D. Eighth Edition; revised. W. B. Saunders Company, Philadelphia, 1927. Pp. 635, with 266 illustrations. Price $3.00.

In this eighth edition the author has revised some of the old illustrations and added many new ones. New subjects, such as iodine and mercurochrome preparation of the parturient for labor; Gwathmey's synergetic obstetric analgesia; and the identification of newborn babies in busy maternities have been added.

First the normal anatomy and physiology of the female reproductive system is briefly described; then follows pregnancy, labor and the puerperium, with chapters on the newborn infant, hygiene of pregnancy and the infant's layette, etc.

In part two the actual nursing care during labor and puerperium is discussed.

Part three considers complications, disorders of the newborn, infant feeding, etc.

In the appendix is found much good material on visiting nursing in obstetric practice; hospital vs. home nursing, methods of sterilization, diet lists, and an outline for study, etc.

DeLee's Obstetrics without question continues to be one of the best textbooks on obstetrical nursing. The author has presented his subject in an interesting and very readable manner, and any student or graduate nurse would by careful study of the text not only obtain full and complete information but also much stimulation for better endeavor in this important branch of nursing.

TADDIKEN.

Nursing Mental and Nervous Diseases. By ALBERT COULSON BUCKLEY, M. D. Pp. 213; 57 illustrations. J. B. Lippincott Company, Philadelphia. Price $3.00.

The volume approaches the study of mental disease with a chapter on general biology. This is followed by a chapter dealing with descriptions of the structure and function of the vertebrate nervous system. While these chapters are brief they pave the way for the study of mental processes in the next three chapters. The various causes of mental illness are discussed in one chapter. Nine chapters deal with the study of mental disease, taking up the symptoms and nursing care. One chapter presents special nursing procedures, including the more important hydrotherapeutic measures, occupational therapy, psychotherapy and mental hygiene. Diseases of the nervous system are of necessity discussed briefly, but the important symptoms are clearly described. There is a helpful glossary and a well arranged

index. The book is printed on good paper with clear type. The subject matter of the volume has been systematically arranged, is concise and practical and should be of considerable help to the graduate nurse as well as the nurse in training. The nursing profession should be grateful to Dr. Buckley for his efforts in producing a book so remarkably complete.

WORTHING.

Text-Book of Nursing Technique. By IRENE V. KELLEY, R. N. W. B. Saunders Co., Philadelphia, Pa. 366 Pages. Price $2.50.

The aim of the author is to give to schools of nursing a text for the teaching of nursing and a reference book for general practice. She has carefully outlined the nursing procedures used at St. John's Hospital, Cleveland, Ohio, and arranged them in the order suggested in the Standard Curriculum for Schools of Nursing prepared by the National League of Nursing Education.

The first section of the book deals with those procedures given the student nurse during the probationary term. The junior year follows and presents during the first semester the procedures used in medical, surgical and communicable disease nursing; and in the second semester, obstetric nursing, pediatric nursing, and nursing in venereal, occupational and skin diseases. The senior year concludes the study and has to do with the nursing in mental and nervous diseases and in diseases of eye, ear, nose and throat.

Each procedure enumerates the articles needed, gives a detailed description of nursing technic, lists the points to be remembered and tells what record must be made on the patient's chart. All unessential matter is excluded and the author deals wholly with the practical side of the nurse's work.

This book is an aid to teachers of nursing because of the arrangement of procedures in logical sequence, beginning with the simpler and leading to the more difficult, the intelligent carrying out of which depends upon theoretical knowledge. Lesson plans demonstrating an excellent method of class presentation are given on pages 79 and 103.

There are many well chosen illustrations throughout the book. Questions following each subject and also several pages of questions and suggested demonstrations at the end of each semester are of decided value.

The chapter on Nursing Procedures used in Mental and Nervous Diseases is not satisfactory and it is to be regretted that it was not written by, or at least revised and enlarged, by someone thoroughly familiar with the care of mentally ill patients.

G. MARION O'DONNEL.

The Natural Increase of Mankind. By J. SHIRLEY SWEENEY, M. D., D. Sc. With Introduction by William H. Welch, M. D. 185 Pages. The Williams and Wilkins Company, Baltimore.

The population problem continues to occupy a prominent place on the economic and social stage. Is the world becoming over-populated? Does the decline in birth rates indicate a lessening of the virility of the race? Is the proportion of the unfit in the whole population increasing? Is birth control to be regarded favorably or unfavorably? These and many other questions are being continually discussed and new data relating thereto are eagerly sought. Dr. Sweeney's intensive study presented under the above title is therefore timely and should attract wide attention.

As the measure of increase of population the author uses the vital index ($100 \times$ births $\div$ deaths). He has worked out this index for all of the countries of the world for which data are available and has presented the results in comparative tables. He has also worked out mean indices and the trends of vital indices in various countries.

After presenting the data with full explanations, the author draws the following significant conclusions:

Practically all countries possess high mean indices. This means that all the races of the world are increasing in numbers and are biologically healthy.

Some populations possess higher mean vital indices than others. The northern European races, the Australian states, Canada and the United States rank especially high. They are therefore considered biologically healthier than other peoples, and are destined to become contenders in the race for peopling the earth's surface.

The vital index seems to depend to some extent on geographical location, the countries near the equator having lower indices than those father north or south.

Vital indices in most countries were found to be increasing.

War and disease do not seriously affect the vital index. Their effect is merely temporary.

The question of over-population is discussed at length and the author draws the following rather startling conclusion:

"It is our belief that there is only one way that nations can avoid the consequences of relative over-population. That is by an international agreement to control numbers by a league of stationary populations. Will it ever become a reality? No one can deny that it is possible. We say to parents: 'Your children must not work' and 'your children must go to school.' Would it be inconceivably absurd to say to them: 'You are at liberty to rear only three or four children' (depending upon the size of the population, mortality forces, etc.)?"

He has no solution to offer relative to the qualitative aspect of the population. He hopes however that progress in human selection may be made in the future.

The book as a whole is interesting reading and a real contribution to our knowledge of the biological status of the populations of the world.

POLLOCK.

Scientific Nutrition in Infancy and Early Childhood. By STAFFORD McLEAN, M. D., New York, and HELEN L. FALES, B. S. Lea and Febiger, Philadelphia. $3.75.

The authors emphasize the limited knowledge possessed by the general practitioner on the subject of nutrition because of the time and attention paid to other instruction in symptomatology and treatment, for instance, rather than to the physiology and nutrition of the normal individual. They bring out the fact that researches have demonstrated the dietary necessary in animals to produce improvement in various directions and that similar studies applying to man are only recently becoming appreciated.

Because much of the knowledge required for the successful practice of preventive medicine is of recent development and because a considerable amount of the information needed for a proper understanding of normal nutrition is not readily accessible to the practicing physician they have brought together a mass of data on nutrition in a complete but simple way so that it is easily assimilated by the nurse as well as by the average physician. No reference works are necessary; each chapter gradually leads one on from the simplest facts in the physiology of digestion to conditions associated with disturbed nutrition.

They first take up the general principles of feeding infants and young children, showing the importance of a properly balanced diet in the normal child, believing that a recognition of the fundamental laws governing the correct feeding of the young will not only achieve and maintain health but aid in the reduction of the incidence of illness.

The book is divided into four parts, the first one of which explains the essential principles of nutrition as established up to the present time and their application to the normal child. Part two considers the disturbances of the digestive tract classifying them under the following headings: Constipation, acute gastric indigestion, diarrheal diseases, chronic intestinal indigestion.

Part three discusses marasmus, rickets and other diseases. Here we see the application of a paraphrasing of an old saw "an orange a day keeps the doctor away."

In part four on the calculation of dietary values the authors have presented in a condensed form such information as may be necessary for the

calculation of the value of any feeding or diet in total calories, their distribution in fat, carbohydrate and protein, as well as the actual content in nutrients. A thorough knowledge of the methods of computations is, of course, requisite before one can scientifically prescribe the kind and amount of food required.

In the compendium, of forty or more pages, are included data in regard to nutritional requirements, the composition of foodstuffs and many convenient statistics.

The use of heavy type to introduce subject matter in each paragraph, with a different title at the top of every page and chapter headings with an abstract make the book convenient for ready reference.

The authors clearly bring out the obligation laid upon the medical profession to acquire a sufficient training in the principles of nutrition so that they may intelligently prescribe for the healthy child as well as for the abnormal.

GRAY.

Applied Bacteriology for Nurses. By CHARLES F. BOLDUAN, M. D., and MARIE GRUND, M. D. Fifth Edition, entirely reset. 12 mo of 245 Pages, with 80 illustrations. W. B. Saunders Co., 1927, cloth, $2.00 net.

In order to keep this book abreast of the important advances in bacteriology the authors have added new material, expanded a number of chapters and rewritten others, besides adding one on chemotherapy. Emphasis has been laid on the immediate application of the subject to nursing and in response to special requests the historical account of the development of bacteriology has been enlarged.

In their effort to bring the subject before the nurse in a clear and concise manner the authors divide the study of bacteria into five heads, as follows: 1. Microscopical examination, showing the morphological characteristics; 2. the staining reactions, whereby bacteria are differentiated; 3. the cultural method, by which the behavior of bacteria is determined on or in different media; 4. the pathogenic effect on various animals; 5. the reactions of the micro-organism toward various specific immune sera.

The first 12 chapters deal with general bacteriology, beginning with an account of Leeuwenhoek and his experiences with the organisms in tartar scraped from the teeth. Succeeding chapters discuss the characteristics of bacteria illustrated by excellent drawings and halftones. The second section of 24 chapters, under the title of Special Bacteriology, considers the various diseases produced by bacteria, from a brief history of the germ to the latest method of treatment by means of vaccines, antitoxins, and other specific sera.

The authors have a happy faculty of presenting each subject in such an

interesting and comprehensive manner that the nurse should not only be able to thoroughly appreciate the importance of bacteria in disease but be in a position to educate the laity in regard to the danger of various micro-organisms and the value of vaccination and the use of antibodies in the treatment of disease.

In chapter 10 is found a partial list of insects which carry disease, while in chapter 11 we find a list of diseases with the special kind of vaccine or serum used in treatment. On page 161 there is a list of the diseases due to filterable viruses. Special chapters on the bacteriology of milk and water add a great deal to the completeness of the book. Certain chapters as that on "quarantine in the control of infectious diseases" and "immunity" are up to the minute and are written in such a simple and plain style that all nurses should be able to grasp every word. The book should be in the hands of every nurse or medical student about to take an examination on this subject.

The printing is clear, very few typographical errors being found; the paper is of the very best; two colored plates illustrating bacillus tuberculosis in sputum (Ohlmacher) and malarial parasites (Deaderick) and many microphotographs help in understanding the context.

To quote the publishers, "Everything new in bacteriology, is included that will be of use to nurses."

GRAY.

Surgical Nursing and the Principles of Surgery for Nurses. By RUSSELL HOWARD. Fifth Edition. Longmans, Green & Co., 55 Fifth Avenue, New York City. Price $3.00.

As the title indicates this book is written especially for nurses, although it is a practical guide in the principles of surgery for medical students. The author develops the book from a series of lectures given to probationers at the London Hospital and has given in a brief way the methods of surgical nursing and details of treatment from the nurse's viewpoint.

The print is clear, the subject matter is illustrated by many schematic drawings and cuts of instruments with an occasional photograph of hospital subjects.

There is nothing unusual found in the author's presentation of the various chapters dealing with infection, inflammation, wounds, the action of microorganisms, etc., except that he uses many typical English expressions and from an American viewpoint retains too many old-fashioned methods.

The description of the technique in the preparation of a patient for operation shows that the author has in mind the dwelling of a middle class Englishman and is so brief that it leaves considerable to the imagination.

It amused the reviewer to note that he reminds one to be careful and have artificial light available in the event of fog.

The same conciseness in handling the chapters on emergency abdominal operations, ophthalmic nursing, etc., leaves much to be desired.

The reaction of the reviewer following a careful reading of the book is on the whole one of disappointment, nothing new is described and the arrangement is in no way unique.

An appendix of seven pages includes various combinatinos for enemata, dosages for common use, drugs, recipes and weights and measures all useful to the nurse.

GRAY.

Diseases of Children for Nurses. By ROBERT S. MCCOMBS, M. D. Fifth Edition, thoroughly revised. Octavo of 581 pages, illustrated. W. B. Saunders Company, Philadelphia, Pa. Cloth, $2.75 net.

In this fifth edition of the work originally published in 1907, the author has made revisions so as to bring the work thoroughly abreast of the recent advancement in pediatrics. Several chapters have been rewritten and new illustrations have been added. New and modified chapters cover mental hygiene, nutritional disturbances, toxin-antitoxin immunization from diphtheria, the Dick Test in scarlet fever, insulin, the milk laboratory, preparation of infant foods and the therapeutic measures employed in childhood. The book is well illustrated and fulfills its purpose most admirably.

POLLOCK.

The Technic of Nursing. By MINNIE GOODNOW, R. N. 12 mo. of 452 pages with 207 illustrations. W. B. Saunders Company, Philadelphia, Pa. Cloth, $2.50 net.

This very complete textbook is intended to replace the author's "First Year of Nursing" which was well received by superintendents of schools of nursing throughout the country. The book is written with the modern teacher and nurse in mind. The author recognizes that methods of teaching nurses are changing and textbooks must conform to altered conditions. The work deals with nursing and nursing only, as other matters that the nurse should know are given in separate courses. The style used throughout is direct, the text consisting principally of a series of explicit directions as to how the various nursing procedures should be carried out. The high standards of nursing advocated by the author are evident on every page. Numerous illustrations assist in clarifying the text.

POLLOCK.

Pediatric Nursing. By GLADYS SELLEW, R. N. 12 mo. of 456 pages, illustrated. W. B. Saunders Company, Philadelphia. Cloth, $2.10 net.

This modern presentation of pediatric nursing is designed as a textbook for nurses and reflects the author's teaching experience of 20 years. She has brought to the book all the helps which simplify the teacher's work and facilitate the learning of the student.

The book consists of two parts, Part 1, dealing with the problems involved in teaching pediatric nursing and with the general care of infants and young children. The second part is more technical and deals with nursing procedures and discusses the various types of care to be given children suffering from different diseases.

The work is well written and well adapted to class use.

POLLOCK.

Fundamentals of Dietetics. By BERTHA M. WOOD and ANNIE L. WEEKS. 12 mo. of 241 pages, illustrated. W B. Saunders Company, Philadelphia. Cloth, $1.75 net.

The aim of this book is to give a course in dietetics for a class of average size in a school of nursing. The laboratory lessons have been arranged for 12 student nurses as this is the usual number in classes in dietetics. The courses have been planned for fifteen 1-hour periods and fifteen 2-hour periods in preliminary dietetics and twelve 2-hour periods in advanced dietetics, making a total of 69 hours. Each lesson consists of a lecture outline and laboratory exercises. The subject matter is well arranged and the laboratory exercises are practical and clearly presented. This manual should help to popularize dietetics in schools of nursing.

POLLOCK.

Materia Medica for Nurses. By GEORGE P. PAUL, M. D., C. P. H. Fifth Edition. Thoroughly revised. 12 mo. of 352 pages. W. B. Saunders Company, Philadelphia. Cloth, $1.75 net.

This is the fifth edition of a very useful and well prepared manual. The subject matter is arranged in six parts, Part 1 dealing with general considerations; Part 2, with general materia medica, therapeutics and toxicology; Part 3, with drugs of minor importance; Part 4, with newer medicinal agents; Part 5, with practical therapeutics, and Part 6, with miscellaneous matters relating to drugs and their preparation.

In describing the principal drugs, the author gives the derivations, synonyms, incompatibilities, physiologic action, therapeutic indications, and toxic properties. The descriptions are clear and concise. Under the head-

ing of practical therapeutics, the author discusses hydrotherapy, hypodermoclysis, disinfection, counter-irritation, application of heat, biologic therapy, massage, electrotherapy and other methods of treatment. The tables given in Part 6 cover a wide variety of valuable information.

Altogether the book well deserves the success it has had and we bespeak a cordial acceptance of this fifth edition.

POLLOCK.

This Business of Operations. By JAMES RADLEY.. 96 pages. The Digest Publishing Company, Cincinnati.

In this interesting story the author, a business man, tells with genial humor his thought and experiences in relation to a general hospital. He held the hospital in dread and although he needed an operation for a considerable period, he postponed the matter until his condition became critical. After reaching the hospital his fear became less and he underwent a serious operation with no misgivings as to the result. His full recovery followed and he left the hospital with gratitude and praise for the kind and skillful treatment he had received. The object of the book is to inspire confidence in hospitals and in the physicians and nurses who conduct them.

POLLOCK.

THOMAS W. SALMON, M. D.

THOMAS WILLIAM SALMON, M. D.

BY WILLIAM L. RUSSELL, M. D.,

GENERAL PSYCHIATRIC DIRECTOR, THE SOCIETY OF THE NEW YORK HOSPITAL,

WHITE PLAINS, N. Y.

The sudden death of Dr. Thomas W. Salmon on August 13, 1927, was a severe shock to all in the field of mental hygiene and psychiatry as well as to a wide circle of personal friends. In a brief span of life he rendered a service of the highest importance and value to the State, to the country, and to humanity. His loss will be long and keenly felt by many public officials, private workers, and a host of others who looked to him for guidance, inspiration and help.

He will be especially missed in the State in which he was born and spent most of his life. He was born in Lansingburg, near Troy, New York, where his father, Dr. Thomas H. Salmon, was a practicing physician. He was educated in the public schools and the Lansingburg Academy. After teaching for a year or two he became a student at the Albany Medical College. He received his degree in 1899, and at once entered into private practice at Brewster, New York. After two years he was obliged to give up his practice because of illness and to spend a short time in the Adirondacks. When he was sufficiently recovered, in the fall of 1901, he accepted a temporary position at the Willard State Hospital. During his service there diphtheria prevailed at the hospital and he made a valuable study of its bacteriology, especially with regard to the spread of the disease by infected well persons. His careful and extensive observations of diphtheria carriers were among the earliest recorded. They were published in a report that appeared in the Annual Report of the State Commission in Lunacy for the year 1904.

In 1903, he received a commission in the United States Public Health Service. He served in the marine hospitals, and in 1905 he was assigned to the immigration service on Ellis Island. At that time the State of New York, aroused by the extent to which the aliens in the population were contributing to the burden of insanity, had established a Board of Alienists and was endeavoring to be permitted to aid the federal government in examining the landing immigrants. The subject of mental disease and defect among the immigrants had been given little or no consideration by the immi-

gration authorities and no psychiatric service was provided at Ellis Island. With a view to acceding in some measure to the demands of the State, Dr. Salmon was instructed to give special attention to the problem. He was at once struck by the sufferings of the cases of mental disorder for whom the treatment provided was of the most primitive and objectionable character. His attention to the subject also revealed a much larger number of cases among the immigrants than had been suspected by the authorities. This evidence of past neglect was not particularly welcomed by the officials and he met with much opposition. He was, however, supported by the State authorities and voluntary bodies who had long been aware of the situation, and finally succeeded in bringing about the system of examination by psychiatrists that is now a permanent part of the immigration medical service. He also planned a suitable hospital building for the treatment of cases requiring it, and did much to establish more humane and effective methods of dealing with the whole problem. In 1911 he obtained leave of absence in order to accept an appointment as chief medical examiner of the State Board of Alienists. During that year he made a special study of the foreign-born patients in the State hospitals in cooperation with the statistician of the Commission. He made many useful suggestions and on several occasions was invited to appear before committees of the Congress and the President. His knowledge and clear understanding of what was needed enabled him to bring about changes in the law and methods that have been of inestimable value to the nation, to the State, and to the immigrants.

His aptitude for statistical presentation led to his being engaged by the Commission in Lunacy in 1908 to aid in the introduction of the present system of statistical studies. The position of statistician had not then been provided and the first studies and charts were made by him. An article on "Errors made in compiling the New Statistical Tables" written by him appeared in the State Hospitals Bulletin for March, 1909. Later, when he was medical director of the National Committee for Mental Hygiene, he was instrumental in having a similar system adopted by the American Psychiatric Association and introduced throughout the country. These nation-wide studies are the most extensive that have ever been undertaken and have furnished invaluable information.

A program for broadening and improving the State system of

dealing with mental defectives which he prepared and presented as a report to the New York Psychiatrical Society, was the inspiration and guide to the establishment of a State Commission on Mental Defectives, and the system of State out-patient clinics, and other field activities that have since been adopted. The demonstrative psychiatric studies made at Sing Sing under the auspices of the National Committee were also planned by him, and he was a member of the Advisory Committee. The plan of reorganization of the prison, with its provision for psychiatric service is principally of his making. He was looked to for advice from many directions and he was so resourceful and reliable that his share in the advancement of the application of psychiatry in dealing with delinquency can scarcely be estimated. Other influences have operated but had it not been for what he contributed, the State would probably not yet have reached the stage of enlightenment that is now revealed in the appointment of a psychiatrist to be head of its prison department.

In 1912, Dr. Salmon was engaged by the National Committee for Mental Hygiene to undertake some special studies for which funds had recently been furnished. Although the Committee had been founded in 1908, it had not before been in a position to undertake practical work. Dr. Salmon was later appointed medical director and it was he who built up the organization, developed its program, and established it in the confidence of the medical profession and the public. His knowledge of State and national problems, and of agencies in the field of mental hygiene and psychiatry, enabled him to think and plan on broad lines. Although many of those actively interested in the work of the Committee were acknowledged leaders in the various fields of endeavor that come within the scope of mental hygiene, his leadership in the planning and executing of every undertaking was pre-eminent. He was fertile in proposing and extraordinarily resourceful in planning and executing. To explain his activities and what was accomplished, it would be necessary to review the history and work of the National Committee from the beginning of his connection with it to the present. Nearly all the various undertakings it has entered into were set in operation by him. Most of them were the outcome of his remarkably broad and clear vision, his sound knowledge and judgment, and his remarkable capacity for enlisting the interest and cooperation of others. He

could plan and work on broad lines but his effectiveness in advising and planning was, in great measure, due to his steadfast adherence to the medical issues. He viewed every situation and every project with the eyes of the physician, and was actuated by their relation to the relief of the sorrows and sufferings of the individual and to the conquest of disease and misery.

Dr. Salmon's services during the World War marked, perhaps, the climax of his career. He saw in advance what the needs would be, and early in 1917, he prepared a plan for the organization of military neuro-psychiatric units for the early treatment and evacuation of cases of mental disorder, and for the elimination of recruits showing mental disorders or deficiency. With Dr. Pearce Bailey and Dr. Stewart Paton, he presented this to the Surgeons General of the Army and Navy. The committee was requested to visit the Mexican border and study the neuro-psychiatric problems among the troops in service there. This was done, and in May, Dr. Salmon also made a visit to Europe and obtained valuable information concerning the methods employed by the countries already engaged in the war. Dr. Salmon's wide acquaintance with the neurologists and psychiatrists throughout the country enabled him to aid greatly in securing a well-trained neuro-psychiatric medical and nursing group. He went overseas with the troops as senior consultant in neuro-psychiatry and organized and administered the service throughout the Army in France. The value of the psychiatric service, not only as a means of preventing and relieving suffering, but of conserving the man-power and morale of the Army was generally recognized. Dr. Salmon was advanced to the rank of colonel, and on his return home, received the Distinguished Service Medal and was placed on the reserve list with the rank of brigadier general. The demonstration in the prevention of the psychoneuroses, and in the early and suitable treatment of these and of the psychoses, was extremely valuable in spreading abroad among physicians and the public an appreciation of the character and usefulness of psychiatry and mental hygiene. It also greatly enlarged Dr. Salmon's acquaintance with the physicians of the country and increased the demands upon him for advice and service.

He felt, however, that his next great task was to endeavor to secure proper attention by the government for the mentally disabled ex-service men. His indefatigable efforts, and his remarkable

ability and personal influence, did, perhaps, more than anything else to shape and carry into effect the program of the hospital provision that was adopted. In 1923, through the American Legion, he was instrumental in interesting the Governor and securing special provision for the care of ex-service men in the State hospital system.

In 1921 he was appointed professor of psychiatry at the Columbia University Medical School, and resigned as medical director of the National Committee. His time and energies were afterwards greatly absorbed in college work and private practice. Notwithstanding his long separation from personal medical practice, his abiding interest was in the sick man, and the renewal of the relationship of physician and patient was a source of great happiness to him. He continued, however, to keep well informed concerning the organized interests in which he had formerly participated, and on occasion to take a hand in advancing them. His advice was sought from far and near. He was a member of many committees. His influence and power of accomplishment through others were very great, and many developments in which he was no longer officially interested bear the marks of them. His latest service to the advancement of psychiatry was in proposing and bringing about the establishment of the State Psychiatric Hospital and Institute at the Medical Centre of Columbia University.

Dr. Salmon wrote many articles for publication and many valuable reports. He also wrote the chapter on "Immigration" in "Modern Treatment of Nervous and Mental Diseases," (White and Jelliffe), 1913. He contributed chapters on mental hygiene in the American Year Book (1916-1920) and a chapter on the "Prevention of Mental Disease" in Preventive Medicine and Hygiene (Rosenau). He was also the editor of the neuropsychiatric section of the Medical History of the World War. He was an attractive and a remarkably convincing and inspiring speaker, and made many addresses before medical and public gatherings.

He was a member of the principal national and local psychiatric and neurological medical societies. He had been president of the American Psychiatric Association and of the New York Psychiatrical Society. He was a member of the New York Academy of Medicine, the American Medical Association, the American Insti-

tute of Criminal Law and Criminology, and of the Association of American Military Surgeons. He was also a member of the Century Club of New York, the Army and Navy Club, and the Larchmont Yacht Club.

He was married in 1899 to Helen Potter Ashley whom he had known and loved since boyhood. Six children were born to them, all of whom, with Mrs. Salmon, survive him.

A recital of his outstanding achievements and of the main events of his life fall far short of revealing the full stature of the man, or the extent of his influence and usefulness. There was a quality to his personality that inspired the greatest respect and admiration. This greatly enlarged his power of accomplishment, and made an enduring place for him in the minds and hearts of all who knew him.

EUGENE HENRY HOWARD
1850---1927

IN MEMORIAM

Dr. Eugene H. Howard

Dr. Eugene Henry Howard, who had been superintendent of the Rochester State Hospital since 1891, died at his home at the hospital August 24, 1927, from pneumonia resulting from injuries received in an auto accident five days earlier. He was nearly 77 years old but prior to the accident was in excellent health and was actively engaged in conducting the affairs of the hospital and in planning for its enlargement. As his long life had been devoted to helpfulness to humanity his death is mourned by thousands of people in all walks of life. He will be especially missed by his associates in the Rochester State Hospital and by his many friends in the other branches of the Mental Hygiene Department.

Dr. Howard was born at Cheektowago, Erie County, New York. He was educated in the Genesee Wesleyan Seminary, Genesee College and the Medical School of the University of Buffalo. He received his medical degree from the last named institution in 1873. Syracuse University gave him the honorary degree of Master of Arts in 1903.

He was resident physician of the Monroe County Hospital from 1873 to 1879, physician of the Monroe County Jail from 1881 to 1885 and superintendent of the Monroe County Asylum from 1885 to 1891. When the asylum became Rochester State Hospital in the latter year, Dr. Howard continued as superintendent and held the position up to the time of his death. This record of successful administration of one institution for 42 years has rarely been equaled.

Dr. Howard's management of the Rochester State Hospital was noteworthy in many respects. Two lines of pioneer work carried out under his direction gave the hospital an international reputation and were important factors in improving the treatment of patients throughout the country. The first of these innovations was the school for dementia præcox patients instituted in January, 1909, under the immediate charge of Dr. Charles T. La Moure; the second was the introduction of social service for paroled patients

under Dr. Howard's personal direction about 1910. Dr. Howard lived to see both of these lines of work assume large proportions in the treatment of mental patients.

Dr. Howard took a broad interest in medical affairs and was active in promoting the interests of the medical profession in Rochester. He was the founder of the Rochester Pathological Society and the Rochester Academy of Medicine. He served both of these societies as president and at various times in other capacities.

Dr. Howard, for more than a score of years, took an active part in the proceedings of the Quarterly Conferences held by the State Department with the superintendents and managers of the State hospitals. As chairman of the Committee on Schools of Nursing, he did much to promote the standardization of the curriculum and the improvement of instruction in these schools.

For several years Dr. Howard was chairman of the Purchasing Committee of the Department, then the State Hospital Commission. His work in this capacity during the trying period of the World War was specially noteworthy.

A fuller review of his services will be found in the accompanying tributes.

Dr. Howard had a most lovable personality. He never tired in his efforts to help others. He had a keen sense of humor and an unfailing fund of common sense. His counsel and advice were freely sought and freely given.

The funeral services were held August 26, at St. Luke's Episcopal Church of Rochester of which Dr. Howard was a member. Those present included executives of the Department of Mental Hygiene, superintendents of many hospitals and institutions, representatives of medical societies, and a large number of Dr. Howard's friends from Rochester and vicinity. Burial was in Mt. Hope Cemetery, Rochester.

MEMORIAL SERVICE IN TRIBUTE TO DR. HOWARD AT QUARTERLY CONFERENCE

A memorial service in honor of Dr. Howard was held at the opening of the Quarterly Conference at Rome State School, September 20, 1927. Tributes were presented as follows:

TRIBUTE BY T. E. MCGARR,
Treasurer, Department of Mental Hygiene

It is a privilege greatly appreciated by me, a layman, to speak before this conference upon the unique personality and achievements of the recently deceased superintendent of the Rochester State Hospital. Presumably, this privilege was granted because of my observation of his official and personal accomplishments based on a friendship extending over two-score years—antedating by several years the taking over by the State from the County of Monroe in 1891, the care of 365 patients together with their devoted physician in charge, Dr. Eugene H. Howard.

In this connection, I recall views expressed by some of the first Commissioners in Lunacy, (with but slight knowledge of Dr. Howard's capacity), as to difficulties likely to arise in his becoming properly oriented as a State hospital superintendent. These were, however, of brief duration, for within a few months after his assumption of the office of superintendent he proved himself to be quite equal to all of its requirements. Uniting with great kindliness of heart, a determined will, clear insight, and a great store of commonsense, he was soon recognized as quite equal in stature to his contemporary superintendents.

Others are to speak of Dr. Howard's civic and professional standing and achievements; my desire is to refer to certain extra-medical adventures of his pioneering spirit. Three or four examples of these stand out clearly in my memory.

I recall first of all the notable reeducational and occupational work initiated at the Rochester State Hospital among the difficult and deteriorated cases of dementia præcox, many of whom had been received by transfer from the Manhattan and Kings Park State Hospitals. In 1909 Dr. Howard assigned to his assistant, Dr. Charles T. LaMoure, the first class of patients, consisting of 12 women of this type; some noisy, assaultive and destructive; others untidy as to dress and indifferent as to surroundings. The first activities in their regard were begun in the amusement hall of the institution, where sustained and efficient efforts were undertaken to get them interested in games and music. In the face of most disheartening obstacles some slight promise of ultimate success was, after a time, noted in an increased neatness of certain of the patients. Relatives and friends, encouraged thereby,

donated clothing of a rather better type to further enhance the improved appearance of these women patients. Subsequently a large room was provided in the basement of the main building and equipped with gymnastic apparatus, and systematic exercises were undertaken under proper guidance. A further improvement in physical and mental conditions was thus gradually brought about. Light tasks were assigned them. Later it was found that patients belonging to this class could be transferred to better wards. Before the close of 1910 the original group of 12 had been increased in number to approximately 40. Writing after a lapse of two years, during which diversional, occupational, and industrial activities, as well as gymnastic exercises, had been steadily increased, Dr. Howard reported:

> "The school is now continued throughout the day and the patients do much better than at the start when but three hours daily were taken up in the work. The mornings from nine to twelve are given up to games, marches, dancing, gymnastics and outdoor exercise; and from two to five in the afternoons efforts are made to teach the different industries. At the present time these patients make all their own blouses and dresses besides doing a considerable amount of work for the sewing rooms. They also do many kinds of embroidery, crocheting, rug weaving and basketry, together with their own washing and ironing; from thirty-five to forty patients are occupied daily; and if we had more room and more teachers we could find many other patients who would be benefited."

As subsequent developments showed, this pioneer experiment afforded a groundwork for the very considerable upbuilding of occupational therapy as we know it today. The "Rochester Idea," as it came to be called, received favorable notice from nearly all parts of the country.

Dr. Howard also was among the first to put into practical operation at the Rochester State Hospital the social service system which has since been so widely and profitably adopted by all of our State hospitals for the insane. His preliminary work dates back to 1906, and reporting in 1913 he refers to the detail of one of his most experienced nurses to the sole duty of visiting the homes of paroled and discharged patients, assisting in every way possible in their readjustment to home living, to prevent, if possible, recurrence of their mental disorder and their consequent recommitment to a hospital. The work has been maintained at the hospital with very gratifying results from that day and with increased appropriations, its scope in this and other State hospitals, has been progressively extended since 1922.

Dr. Howard might also be regarded as a pioneer in the establishment of farm colonies. He was specially interested in the development of what has become the very successful Lake Shore farm colony, located at Webster on the shores of Lake Ontario in the midst of a very fertile district in which

the activities of patients detailed from the Rochester hospital could be directed. I quote from notes on the operation of this farm several years after its start in the spring of 1903:

> "A sojourn at the lake farm offers time and a favorable opportunity for psychotherapeutic nursing; for the training of patients into right habits of thought and action. This camp must not be made too large but must be essentially a recreative and therapeutic center. It must not be exploited for economical and industrial ends to the exclusion of more important functions. It should not become institutionalized; the atmosphere of farm life and its summer camp should be preserved."

For a period of eight years, four of them being those of the World War and four the period succeeding it, when markets of all kinds were thrown into utmost confusion, Dr. Howard served as chairman of the important Purchasing Committee for State Hospitals. I was acting as executive assistant of the committee during this period and this gave me opportunity to study the logical working of his mind.

Soon after the government assumed charge of the railroads, serious transportation troubles occurred. One result of these was a falling off of 50 per cent in the number of bidders for supply contracts controlled by our committee. Later the situation was complicated by a coal strike which caused much distress, especially to institutions unsupplied with sufficient storage capacity. Certain limits as to cost were imposed by the Federal government and this gave rise to threatened loss to contractors. In vain did certain of them, supplying coal and different hospital staples, endeavor to withdraw from their contracts (especially in cases where they were offered higher prices for their supplies) using every device known to thoroughly sophisticated traders. They could never quite understand the chairman of our committee; he listened so patiently to them, (most of the time wearing that quizzical smile of his), that they were certain he was in their corner. Later, however, in executive session, when his associate committee member, Dr. Harris, would burst out: "We've had enough trouble with this crowd; we must reject all future bids from them; let's cut off their cursed heads now once for all. The Chairman would say, "I agree, but let us give them the benefit of clergy"; whereupon the culprit would be called in and after his outrageous delinquencies had been clearly shown to him and proper penalties imposed, he was permitted to leave, a sadder but a wiser man. Not once did Dr. Howard fail to scent double dealing and not once did he fail to flay the double dealers. The welfare of patients was paramount in his mind. He was a modern prototype of Leigh Hunt's Abou Ben Adhem. for if ever there was a lover of his fellowmen it was he. I might cite a small but significant instance. Upon assuming the Chairmanship of the Purchasing Committee, he commented upon a practice which had prevailed for some

time in the committee's work in the purchasing of women's dresses and dress goods. I think I quote him correctly as follows:

> "I object to this practice. It restricts too greatly the patterns and diversity of material. When my patients walk the streets of Rochester together in any number, they are spotted at once as institutional inmates and this because the patterns of the dress material bought by the committee are so very similar. This is cruel and I can prove to you that there is no economy in it and that by making use of bargain days in any city near the institution, you can, especially at the close of the season, get, 'at lower price, a far greater variety of patterns and thus avoid this miserable uniformity.' "

Dr. Howard was a leader in the movement begun early in the 90's for the addition of women physicians to State hospital medical staffs. He had found from actual experience, that is, through the employment of that accomplished physician, Dr. Eveline Ballintine, the splendid service which women can render in this capacity. To a colleague, who opposed the proposed law making such employment compulsory he said: "You come to Rochester on a visiting day and observe Dr. Ballintine's handling of visitors and friends of patients and you'll be convinced that there are decidedly two sides to this question."

As a psychiatrist Dr. Howard admittedly stood high both within and outside the borders of our State. To indicate how highly he was esteemed by our Commission I might mention the fact that he was made an associate of Drs. Pilgrim and Hurd on a committee appointed nearly thirty years ago to visit the hospitals of Massachusetts and other States to find the best man to head our newly-created Psychiatric Institute. I have it from Dr. Pilgrim that Dr. Howard's wise, careful and constructive suggestions were of very great importance in the selection of the distinguished Dr. Adolf Meyer to occupy this important position.

Nothing pleased Dr. Howard better than to spur his assistants to developing their capabilities in medical work along safe and sane lines. Sufficient evidence of this can be found in the high professional achievements of Drs. Elliott, Ballintine, Hanes, LaMoure, Nickerson, Packer and Van DeMark. He told his assistants that no opportunity for self-improvement should be neglected. On one occasion when a furious storm was raging in Rochester and a medical meeting was being held down in the city, he noted one of his assistants reading in his room and asked him why he had not gone to the meeting. The assistant gave as an explanation the violence of the storm. To this Dr. Howard replied that as for himself he couldn't remember attending any medical meeting at which he hadn't learned something he hadn't previously known. This young physician told me that this resulted in his

attending many subsequent medical meetings at times in the face of strong attractions elsewhere.

I must not fail, in closing, to refer to the invaluable service rendered by Dr. Howard while serving as chairman of different Conference committees particularly the important one on State Hospital Training Schools; and also as vice-chairman of the Committee on Dietary and Food Supplies; also as a member of less important committees. In this work, his experience, his insight, his robust commonsense and his gift of felicitous expression found its best exercise in the working out and reporting of solutions of administrative problems which at first seemed insuperable.

Dr. Eugene Howard, the Dean of this Conference of Executives of New York State Hospitals and Institutions, the sagacious and sympathetic superintendent, the big-hearted, deep-chested and lovable man, is no more. He has fought the good fight, he has finished the course, he has kept the faith; who that knew him well can doubt that for him there is laid up the crown of righteousness in a world less burdened with sickness, sorrow, duplicity and frustration.

Tribute by Dr. Robert M. Elliott,
Superintendent, Willard State Hospital

Dr. Eugene H. Howard, superintendent of the Rochester State Hospital, died August 24, 1927, following an injury sustained in an automobile accident five days previously while on his way to visit Mr. William L. Parkhurst, a former State Hospital Commissioner, who was ill at the Genesee Hospital. The funeral services were held at St. Luke's Episcopal Church, of which Dr. Howard had been a member for fifty years. In addition to accounts regarding his work and expressions of appreciation, all of the Rochester papers published editorials on his achievements and personal qualities. Governor Smith telegraphed to the Board of Visitors that because of the great service which Dr. Howard rendered to the State of New York the State had suffered a distinct loss.

Dr. Howard was born in Erie County October 30, 1850, but early in life moved with his parents to a farm at Leicester, near Geneseo, in Livingston County. He attended the local school at Cuylerville and the Lima Seminary, graduating from the latter in 1870. In 1903 Syracuse University conferred the degree of Master of Arts upon him as a distinguished graduate of Lima Seminary, which had merged certain of its interests with that University. He was for many years a trustee of Lima Seminary. He graduated in medicine from the medical department of the University of Buffalo in 1873, and commenced the practice of medicine in the city of Rochester. On April 1, 1885, he was appointed medical superintendent of the Monroe

County Insane Asylum. When the State Care Act was passed in 1890 Monroe County was exempted from its operation, chiefly because of the standard of care prevailing at the local institution, which Dr. Howard was instrumental in bringing about. In July, 1891, the asylum, which contained about 350 patients, became the Rochester State Hospital. It then devolved upon Dr. Howard to take steps for the enlargement of the institution and organize it on a new basis. An appropriation was made the first year for a group of new buildings which were quickly completed. In company with J. Foster Warner, the local architect in charge of this work, he visited all the then existing State institutions, where he was cordially received and given such information as he wanted. He was a keen observer and quick to adopt new methods.

The minutes of these quarterly conferences since their inception 36 years ago, and I have most of them in my library, testify to the active part he took in shaping the policies of the hospital system, especially in the earlier years which might be called the formative or transition period. In 1897 the medical profession of Rochester tendered him a complimentary dinner, and the Lunacy Commissioners in acknowledging the invitation sent to them wrote as follows:

Commissioner Wise: "I wish to state that this mark of recognition is well placed. Dr. Howard has rendered a marked public service in giving up his life to a work that is neither wholly agreeable or fully rewarded. His services, however, are appreciated by his fellow professional men and this is a reward beyond material things. It gives me pleasure at this time to state that Dr. Howard stands high in the councils of the State commission and his advice always receives serious consideration. We feel that he is the right man in the right place."

Commissioner Goodwin Brown: "Permit me to acknowledge your very kind invitation. I can say nothing but of the high esteem in which Dr. Howard is held by myself. His administration of the Rochester State Hospital has reflected the greatest possible credit, not only on the State, but on all who have the good fortune to be connected with this institution. He has shown zeal, efficiency, integrity and executive ability of the highest order. To Dr. Howard belongs the credit for what has been accomplished. There is one particular trait of character that has made Dr. Howard especially valuable to the State and it is this: He has never refused to adopt an idea because it did not originate with himself. He has always been broad-minded, skillfully avoiding enmities and continually making friends. I trust that he may long be spared to conduct the institution of which he is the head and which has furnished such valuable results to the State."

Commissioner Henry A. Reeves: "The society does well to recognize the public services of Dr. Howard as superintendent of the Rochester State

Hospital, in whose evolution out of the Monroe County Asylum he had the leading and potential part. In honoring him the society honors itself. A generous recognition of such qualities of masterful and tactful guidance as he displayed in the transition stages and discreet direction in its subsequent development is a tribute richly due to him. As one who has had frequent and ample opportunity to note the pervading character and the actual work done by Dr. Howard I claim the right to add my mite of hearty commendation to the general acclaim. The commission in lunacy has found no more zealous or more sagacious supporter in the long struggle to establish the beneficent policy of State care for the insane; no more earnest or successful coadjutor in carrying out that policy; no more faithful upholder of the general scheme of lunacy administration than Dr. E. H. Howard. Let me offer to him and to you my cordial congratulations on the occasion which brings you together."

Dr. Howard was chairman of the Committee on Training Schools for nearly 20 years and served on a number of other committees for long periods; he was also chairman of the Purchasing Committee for a time until its discontinuance, when the central purchasing department was established. He was one of a committee of three to select a director for the Psychiatric Institute at the time Adolf Meyer was appointed. It was his belief that there were many patients in the various hospitals who, although not recovered, might be paroled to the custody of relatives and friends without detriment to the public welfare or the patients themselves, and was the first to call attention to this at one of these conferences and recommend that an effort be made to relieve the hospitals of as large a number of this class as possible. In a paper read at the Quarterly Conference in February, 1913, he stated that for some years previously there had been an average of 100 patients at home on parole from the Rochester hospital out of a population of 1,500, and that if this proportion could be maintained throughout the State the number constantly on parole would exceed 2,000. At the close of the fiscal year ending June 30, 1927, the number of patients on parole from the civil hospitals was 3,487. He was also one of the first to establish a system of supervision or after-care for those on parole. The Rochester hospital was the first in this State to establish a school of physical training for those afflicted with dementia præcox.

The adage that "A prophet is not without honor save in his own country" did not apply to Dr. Howard. His activities in the city of Rochester were many and varied, and no physician there was more highly esteemed by the medical profession or the citizens of that great city whose population during the 42 years of his superintendency had increased from 100,000 to 340,000. He was a member of all the local medical societies, and the Rochester Historical Society, had been president of all of them, and much of the time he

filled minor offices. He was one of the organizers and a charter member of the Rochester Pathological Society and continued active in it through its more than 50 years of existence; two years ago he was the guest of honor at its annual dinner. He was much interested in the greater University of Rochester development, especially in the school of medicine, and advocated a plan, which was being worked out, of offering the facilities of the State hospital to the students of the school of medicine for the study of psychiatry. The hospital was familiarly spoken of as "Dr. Howard's place." When the establishment of a State colony for epileptics was under consideration he was consulted, and with others was invited to inspect the proposed site at Sonyea; I remember very well when he was visited by Dr. Frederick Peterson of New York, who initiated the movement for the establishment of Craig Colony. In 1923 he took a leading part in his district in the campaign for the $50,000,000 bond issue for the State hospitals and feebleminded institutions, speaking before a variety of clubs and other organizations; his statements carried great weight and impressed all who heard him. He gave lectures on mental nursing at the city hospital, was much in demand as consultant, and as an expert alienist in court cases. He became a member of the American Psychiatric Association in 1888.

But Dr. Howard's professional ability and his achievements at Rochester did not account for the high regard and esteem in which he was so universally held, although they went far to explain it. What, then, was it? It was the greatness of his personality, the width of his human sympathy, the bigness of his heart. When we were near him we were near a great glowing mass of essential human goodness, human talent, and we could not but be quickened by the genial warmth. As one of his associates has said: "He was an unusual personality. It was the very essence of his nature to be kind and helpful and nowhere were these traits more appreciated than among the employees and staff of the hospital and the patients. He always was going out of his way to make others more comfortable and happy. He had a judicial mind, and when a subject was presented to him he could show both its weak and strong points and render a judgment that was both fair and reasonable." He was not a martinet; no man constituted as he was could be that, and his method of dealing with those about him was sometimes misunderstood and misinterpreted by those who did not know him. The Democrat and Chronicle in concluding an editorial on the death of Dr. Howard stated as follows: "It is however, more important to note and recall his qualities as a man, and it will be for these, perhaps, that he will be longest remembered. No one could have had the success he had in dealing with his difficult charges without possessing unusually broad sympathy and understanding of human values. Dr. Howard had this sympathy and understanding to an unusual degree, and it unquestionably made his

science and his industry of immeasurably high value to this community and to the State."

TRIBUTE BY M. BRUCE POTTER,

Member of Board of Visitors, Rochester State Hospital

At the last meeting of the Board of Visitors of the Rochester State Hospital, I was asked to represent the Board at the Memorial Service at this Conference in honor of Dr. Eugene H. Howard.

Although I have only known Dr. Howard personally for a few years, I have always heard of Dr. Howard's place on the hill.

In reviewing the past one finds that Dr. Howard was born October 30, 1850, in Erie County; that he graduated from Genesee Wesleyan Seminary, now Syracuse University, Genesee College and Buffalo Medical College, receiving his medical degree with the class of 1873. After graduation he came to Rochester and was appointed an interne at Monroe County Hospital and remained there until 1875. In April, 1875, he was appointed warden of Monroe County Almshouse, leaving there in January, 1880. He engaged in the private practice of medicine in Rochester. On April 1, 1885, he was appointed medical superintendent of the Monroe County Asylum for the Insane and continued in that capacity until July 1, 1891, when that institution was taken over by the State and henceforth has been known as Rochester State Hospital in the State at large, but to the people of Rochester as Dr. Howard's place. It was a common expression among the citizens of Rochester when one presented any unusual ideas or extravagant theories, to be told "Look out or Dr. Howard will get you," simply showing that he was known all over the community.

Up to the time of my appointment on the Board of Managers early in 1924, I had never met Dr. Howard, but soon came to feel that I had always known him, and looked forward to the monthly meetings of the board, because of his genial and winning manner. He was always of an even disposition and jovial; he often took great delight in presenting topics that would bring about active discussion of subjects foreign to hospital affairs which would tend to touch up the monotony of the board meetings.

More recently he realized that his time for retirement was drawing near and because of his personal problems he was somewhat apprehensive and much concerned. He intimated his wish to continue in active life in his chosen profession until such time as his difficulties might be solved, but without warning and from unforseen causes his career was suddenly terminated on August 24, 1927.

His death has brought to an end a long life full of accomplishments and his record remains as a testimony to his unusual abilities.

Tribute by Monsignor York,

Member of Board of Visitors, Kings Park State Hospital

I have known Dr. Howard for 25 years. He was the dean of the service not only in years, but likewise in experience, culture and nobility of character—in fact, in every way that a man can be considered.

He was born noble—"noblesse oblige." Not that he ever considered himself better than his fellows, but his motto was "always to serve."

Nobility puts an obligation of service on a man. He was the most cultured, tenderhearted and lovable man in the service. He played the game fair. He belonged to no clique. He wanted no political influence neither in nor out of the hospital. He lived the life of the Cross. He lived the human life, in touch and sympathy—with his fellows and especially the mentally afflicted. He did the work of Christ. Our Savior lived a visible life of public ministration for three years. Dr. Howard lived a life of ministration to the afflicted for 42 years.. Our Savior touched the lunatic with but his finger and cured him. Dr. Howard touched the lunatic not for three years only but for 42 years—and touched them and healed thousands through his assistants, nurses and attendants.

Our Lord visits and cures the sick through the Howards and men and women like him who carry on in their day the work of the Master, which if they did not do it, would be left undone. Dr. Howard spent his whole life in one place, the Rochester State Hospital doing good.

The first time I met Dr. Howard I made the impression on him that I was a light-hearted, perhaps frivolous person. It was not until years later that he changed his opinion. And the occasion was the memorial service for Dr. Mabon. I spoke on that occasion and made a prayer. Dr. Howard came over to me and shook my hand, and warmly complimented me and said he never thought there was such depth of character in me as was revealed in that speech and prayer. We became warm friends. I loved him for his benevolence and kindliness. He never made trouble for himself or others. Now that he is gone I feel I should utter a prayer such as I did for Dr. Mabon.

I pray God to grant his soul eternal light, refreshment and peace in the Kingdom of the Blessed. And may the good God grant this not alone to his soul, but to the souls of the thousands who labored in the service for the care of the insane and have passed on to eternal life. And may his soul and theirs rest in the eternal peace of our Lord Jesus Christ.

LAYING OF THE CORNERSTONE OF THE NEW YORK STATE PSYCHIATRIC INSTITUTE AND HOSPITAL

The ceremonies in connection with the laying of the cornerstone of the New York State Psychiatric Institute and Hospital took place on September 17, 1927, at the Columbia University Medical Center, 168th Street and Haven Avenue, New York City. Governor Alfred E. Smith and a distinguished company, including many outstanding leaders in the political, educational, medical, humanitarian and industrial life of New York City and State, were present.

Addresses were made by representatives of various organizations and official bodies interested in the development of the new Institute at the Columbia Medical Center. Dr. George H. Kirby, director of the State Psychiatric Institute and Hospital, presided and introduced the speakers. The following addresses were delivered prior to the laying of the cornerstone by Governor Smith.

Address by the Chairman, Dr. George H. Kirby

Governor Smith, Ladies and Gentlemen: We have assembled today to witness a unique ceremony, the laying of the cornerstone of the first psychiatric institute and hospital ever constructed in the State of New York.

This project now nearing completion has been many years in maturing, so long a time, in fact, that some have in the past felt that the plans for such an institution, which have been under consideration for 25 years or more, would never be consummated. However, through a most fortunate combination of circumstances affording an opportunity for cooperation between the State of New York and Columbia University, success has been finally attained—and attained on a scale and amid surroundings which a short time ago would have been considered hardly within the range of possibility.

Nothing, however, could have been accomplished without the active support of Governor Smith, who as soon as the plan was brought to his attention, gave it his enthusiastic endorsement. Everyone knows of the Governor's deep concern for the welfare of the wards of the State and of the enlightened and progressive policies which he has inaugurated for the rehabilitation and modernization of our State institutions. His approval of the recommendation that part of the bond issue money be used for the purpose of building the new Institute showed his appreciation of the need for such an institution and his belief that it would furnish a valuable service to the people of the State and open the way for a far-reaching program of scientific achievement and educational advancement in the field of mental health.

As presiding officer, it is my privilege to present to you this morning some of those who through their interest, help and cooperation, have made possible the splendid achievement which we commemorate today. It is a great disappointment to us and a cause for deep sorrow that the one who first conceived of the idea of this conjoint development between the State and the University is not with us today to witness the fruition of the plan in which he was so deeply interested. The sad death of Dr. Thomas W. Salmon has deprived us of a loyal friend and removed a most distinguished leader in the field of psychiatry and a pioneer in the promotion of mental hygiene in this country.

One of the first persons who gave his unqualified support to this enterprise and who was largely instrumental in concluding a satisfactory agreement between the State and the University was Dr. C. F. Haviland, formerly Commissioner of Mental Hygiene. With Dr. Haviland's retirement, the duties and responsibilities in connection with the completion of the plans fell on the shoulders of his successor, Commissioner Frederick W. Parsons.

Dr. Parsons, with his characteristic energy and ability has spared no effort to further the development of the new Institute and to insure its successful inauguration. I have the honor to introduce the Commissioner of the State Department of Mental Hygiene, Dr. Frederick W. Parsons.

ADDRESS BY DR. FREDERICK W. PARSONS, COMMISSIONER OF MENTAL HYGIENE

When a great State embarks on a philanthropic course as important as the one represented by this structure, it is fitting that suitable notice be taken of that fact. When it stands with its shoulder to the shoulders of a group of hospitals and a great university, uniting its effort with theirs, it is a still more notable instance of progress. That these privately owned corporations long devoted to the welfare of mankind should be willing to have in their midst a State-owned institution indicates the degree of respectability which has been attained by New York State and the institutions which she has founded and maintained for the care and treatment of such of her citizens as have become mentally sick—sick in a manner, not so long ago, regarded as a reproach. Now of course the world knows better. It knows that mental ill health is no more reprehensible than physical ill health. It knows that persons with sick minds need hospitals, not asylums or mad houses, and I am glad to say that this State, of which we all have so many reasons to be proud, early took that stand and occupies a proud place in the annals of modern mental medicine.

This Institute and Hospital promises to be a beacon. Here New York State hopes to do more for its citizens than ever. It hopes to find, by careful research, ways and means to help those for whom it has not known how

to do all that it wished. It hopes to interest and instruct countless persons. It hopes to bring to physicians and nurses measures for the relief of those to whom they will minister and to furnish a light to guide those who stumble. This lofty structure, rising from the earth and rearing its head to the skies, is emblematic of the character of the work which it will shelter: Lofty ambitions with a firm scientific foundation. The Department of Mental Hygiene has great hopes of the structure which you, Governor Smith, today dedicate to its high purpose and I am glad that into this beautiful building went painstaking craftsmanship, thought worthy of recognition by you. Hands of skill built into this building lasting beauty and when this structure is delivered to the Department of Mental Hygiene, may the work done therein merit the praise and be as self-evident as that which is today being recognized.

To the Chief Executive and to members of the Legislature who made this building possible, were given large hearts and broad minds.

Chairman Kirby: For over 25 years the State Charities Aid Association has played a leading part in every effort made to improve our State hospital system and to advance the standards of care and treatment of the mentally sick. For years the Association has advocated the establishment of a research and teaching institute, equipped with adequate facilities for the scientific investigation of the causes, cure and prevention of mental diseases.

The distinguished secretary of the Association has been unceasing in his efforts to interest State officials, the medical profession and the general public in the far-reaching importance of mental disorders and the need for an organized and coordinated effort to stem the rising tide of mental illness. What has been accomplished in this State is due in a large measure to his able leadership. I take pleasure in introducing the secretary of the State Charities Aid Association, Mr. Homer Folks.

ADDRESS BY HOMER FOLKS, SECRETARY, STATE CHARITIES AID ASSOCIATION

This locality, overlooking Riverside Drive and the Hudson River on the west, and facing the astonishing sky-scraping buildings of the new Medical Center on the east, is highly charged with the characteristic spirit of modern American civilization. It was only 320 years ago, a span which would be covered by four lifetimes of eighty years each, that Hendrik Hudson's boat bore the first white men up the Hudson River. Along its banks one can almost see the red men hiding behind the trees and rocks, and hear them questioning which of the Great Spirits were coming to join them, and whether their intentions were friendly or hostile. Now, the clouds which float leisurely over the lower Hudson are pierced daily by aeroplanes speeding across the continent. Shortly there will be opened a tunnel through

which long processions of horseless chariots will pass back and forth daily between the sovereign states of New York and New Jersey. A few days later we shall lay the cornerstone of a bridge over which they will cross in mid-air. Today we lay the cornerstone of a very modern building, twenty stories high on one side and ten on the other. All about us is a marvelous complex of prosperity, speed, invention, ceaseless activity, color, and much ambition and emotion.

In the texture of this latest type of human life, with its many bright and somber threads, perhaps the most somber of all is that with which we are concerned today. Mental disturbance imposes a heavier load on the shoulders of the community, thwarts more legitimate human hopes and plans, breaks up more families, and accounts for more unhappiness than any other one factor in modern life. The State carries an annual load of many millions of dollars for the support of the insane and with all its wealth and constructive energy seems to struggle in vain to build enough hospitals for their care.

In planning and building this Psychiatric Institute and Hospital, the State is moving on its highest level of wisdom and efficiency. Here will be found not only sympathetic care and professional skill, but also the libraries, the laboratories and the clinics, in which all that has been learned on these obscure subjects will be brought together to facilitate the processes of restoration.

But what is really being built here is something quite different from anything which you will find put down on the plans. You will find on the plans, wards for the various types of mental and nervous difficulty; wards for men, for women, and for children; you will find clinics, laboratories and libraries; but what is really being built here high up into the air is something different—it is a sum total of opportunities and facilities which it is hoped will attract and retain that most intangible, rare, but precious thing—the Spirit of Research.

As we provide homes for the birds which we are confident will come to us through the air, so we are setting up here a home and workshops for those choice spirits, few in number, coming often from obscure localities, unheralded, who have been favored with that peculiar gift of an inclination and an aptitude to increase the sum total of human knowledge in regard to mental factors. If this library, laboratory, hospital and clinic should operate simply as routine affairs, they would be useful but really have failed. Among the undergraduates and the post-graduate students of medical and related sciences, now here and now there, there appears the research type of mind and among this small number there will be a small fraction with a particular aptitude for this mental field. This institution and hospital must make its opportunities and influences so widely known that it will

inevitably attract to it those having this rare gift. Having found them, it must enable them to work in their own time, in their own way, according to their various intuitions, on these intricate problems about which we have to do so much, but really know so little.

Research is the highest type of education and of State action. It is not like anything else; it can neither be bought nor commandeered. It begins with a large element of the art of forgetting—of putting aside the untruths and the half truths which have been embodied in traditional phrases and pass currently for knowledge, and of looking at facts, at human behavior, simply, without prejudgment or prejudice. When clues, leads, and intimations are received, there must be intense and unremitting labor in following them to the end.

If there was ever a subject which cried aloud for research, it is this field of mental troubles. Perhaps to most people, while the need is admittedly enormous, the probability of fruitful study may seem slight. Perhaps we do not seem to be on the eve of a solution of any of these intricate problems; perhaps we have to start pretty far back as compared with many other lines of medical research. Even so, we are fully entitled to enter upon psychiatric research with the utmost optimism. No one can have caught even a few glimpses of the ways in which knowledge is being extended in every direction by leaps and bounds, about things great and small, the uttermost limits of the universe, the most minute cells of our own bodies, the makeup of the atom, the long story of the past of man and the world he lives in, in every subdivision of every division of the great field of science—without being convinced that this subject is not to be a great outstanding exception, to remain wrapped in the mystery and traditions which have clustered about it since the days of "possession by devils." We are entitled to have every confidence that some of these mysteries will be cleared up, some of the burdens lifted; that the confusions and distresses of many thousands of human beings will be relieved. It must be beyond doubt that some at least of the many factors in this vast and somber section of human life, hospitals for the insane and the families from which the patients came, will become things of the past, along with pestilences, needless deaths from surgical infection, and other specters which haunted the human race for ages and which have practically ceased to exist within a few decades.

Governor Smith has a high privilege in representing the people of the State in laying this cornerstone today. It is a privilege which comes to him because of his courage and because of his resourcefulness in setting in action more rapidly and more effectively the great resources of the Empire State for the relief and benefit of its most helpless members. Governor Smith will have many agreeable things to look back upon, connected with his days as Governor of this State, when he comes to approach a more contemplative and less active age, and among all these pleasant things I am confident there

will be no one to which his mind will recur with a greater sense of satisfaction and of duty well done, than to the essential part which he has taken in bringing into existence the beneficial institution whose cornerstone he will lay today.

Chairman Kirby: On the adjoining plot of land to the east another splendid building of twelve stories or more will soon arise and become our next door neighbor—the New York Neurological Institute. The problems of neurology and psychiatry overlap and intermingle, but unfortunately these two branches of medicine have generally been approached separately by groups of physicians who have had too little contact with each other and too little understanding of each others' problems and methods of work.

These two institutes, the Neurological and the Psychiatric, standing side by side and working in close cooperation will furnish an unparallelled opportunity for the prosecution of clinical studies and laboratory researches in diseases which should be studied from the standpoint of both the neurologist and the psychiatrist. Such collaboration is bound to be of great scientific value, and furthermore, will be of great benefit to the patients in both institutions. I take pleasure in introducing Mr. Robert Thorne. President of the New York Neurological Institute.

ADDRESS BY ROBERT THORNE, PRESIDENT, NEUROLOGICAL INSTITUTE

It is an honor and a pleasure to participate in the ceremonies attendant upon the laying of this cornerstone, and to have this opportunity of congratulating the Governor and the State of New York on the great forward step for the public welfare that is signalized by the erection of this building.

This occasion in a way marks the coming of a new era in the attitude of the public mind toward mental afflictions and disorders. It has been a slow and halting progress from the witchcraft of the days of our ancestors when a person mentally afflicted was thought to be possessed of an evil spirit or the victim of an evil eye, to the public consciousness of today of which this noble Hospital and Institute is a concrete expression, that a mental disorder or derangement, just like a physical disorder or ailment, is a disease which may be, and often is, curable and which should be made the subject of care and treatment and of study and research in order to discover its symptoms and causes, and search out methods of prevention and treatment and cure.

The growing strain and complexity of our modern life has brought about a great increase in nervous and mental disorders, and the State of New York, under the wise and far-sighted leadership of Governor Smith, in providing for the erection of this building as the first step in its new and enlightened policy and program under a unified Department of Mental Hygiene, has blazed the trail to a new conception of the opportunity

and duty of the State to promote the public welfare and to advance the cause of human happiness by an active and organized effort to meet the ever increasing problem of mental disease by scientific research, investigation and education.

The fields of neurology and psychiatry are closely related, and indeed overlap. The Neurological Institute, of which I have the honor to be the president, will shortly begin the erection of its new hospital upon an adjoining site, looking forward to very intimate relations and very active cooperation with this Psychiatric Institute and Hospital in the great common field of research and investigation to reach a better knowledge and understanding of nervous and mental diseases, and to discover more effective methods of prevention and cure. Such a practical joinder of effort in scientific study and research on a large scale in the two fields of neurology and psychiatry has been dreamed of by the great leaders in both branches, but never before realized, at least in this country, and its value and its promise for the welfare of mankind cannot be over-estimated.

To you, Governor Smith, and to you, Commissioner Parsons, I say that the Neurological Institute accepts the invitation of the State of New York to join hands in a great and united effort to solve the common problems in the fields of neurology and psychiatry, and as I have said I believe that in this union of effort the future holds untold possibilities for successful achievement in the combat against mental disease which is the cause of so much human misery.

Chairman Kirby: One of the great drawbacks to the progress of psychiatry has been the lack of a close affiliation with general hospitals and the lack of facilities for applying the methods of internal medicine in the study and treatment of mental patients.

The location of the Psychiatric Institute in this Medical Center, in close proximity to the great Presbyterian Hospital, will overcome this difficulty and afford a splendid opportunity for cooperation between the psychiatrist and specialists in practically every branch of medicine.

Such an affiliation is bound to throw light on various obscure problems and diseases in the fields of both psychiatry and general medicine, with the result that our knowledge of the causes and treatment of various diseases, both physical and mental, will be greatly enhanced. I take pleasure in introducing Mr. Dean Sage, President of the Presbyterian Hospital.

ADDRESS BY DEAN SAGE, PRESIDENT, PRESBYTERIAN HOSPITAL

These exercises commemorate a final stage in the long and arduous road that the Empire State has travelled in providing care for her suffering and needy residents. Each recent step along this road has been sustained and guided by the broad visioned Chief Executive so happily present today.

We celebrate a union of far-reaching moment to our citizens. The State of New York joins hands with Columbia University, one of America's oldest and greatest institutions of learning; it joins hands with the Presbyterian Hospital which for over half a century has served the people of the City of New York without regard to race, creed or color; it joins hands with the Neurological Institute, the Sloane Hospital for Women, the Babies Hospital, the Vanderbilt Clinic. This joining of hands betokens a consecration of material resources and spiritual endeavor to the highest of enterprises, the conservation of public health. Upon the site of this Medical Center there rises a great laboratory devoted to the three branches of medical science, that is to say, to medical practice, medical research, and medical education. These three are interdependent. Their themes are interwoven. They deal with the drama of human life to be staged in this laboratory. It is fortunate indeed that the State of New York is to be one of the principal actors. We who play the other roles are proud of the association. The cast will hold no star. Where all is dedicated to public service there can be no choice of place.

Through the New York State Psychiatric Institute and Hospital the taxpayer takes his stand beside the philanthropist in this trial of the science of preventive medicine and healing. The contributions of each are pooled to a common end, the alleviation of human suffering.

It is not too much to hope that the adventure here undertaken will entitle a chapter in the annals of medical effort, honorable to the participants, and freighted with benefit to the people of this City and this State.

Chairman Kirby: All of the activities of this great Medical Center are to be coordinated and unified by the Joint Administrative Board representing Columbia University and the Presbyterian Hospital. It was through the sympathetic interest of the Joint Board in the plan to develop a psychiatric service in the Medical Center, that an agreement was finally reached and this plot of land was donated to the State to become the site for the new Psychiatric Institute and Hospital.

In supporting this plan to attack one of the greatest medical and economic problems of our day, the trustees of the University and the members of the Joint Administrative Board have rendered a signal service to the State of New York and to the cause of medical education and have thereby increased the opportunities for the alleviation and cure of one of the most distressing afflictions known to mankind.

I have the honor of introducing a distinguished engineer, a leader in many humanitarian enterprises, the Chairman of the Board of Trustees of Columbia University and Chairman of the Joint Administrative Board, General William Barclay Parsons.

ADDRESS BY GENERAL WM. BARCLAY PARSONS, CHAIRMAN OF THE JOINT ADMINISTRATIVE BOARD OF THE MEDICAL CENTER AND CHAIRMAN OF THE TRUSTEES OF COLUMBIA UNIVERSITY

In the buildings approaching completion that surround us, and in the other buildings that soon will be begun, Columbia University, the Presbyterian Hospital, the Neurological Institute, the Babies Hospital, and other associated organizations are creating a great cooperating institution where medicine and surgery in their many branches may be taught and practiced for the benefit of mankind without regard to race, creed or color. Now the State of New York comes forward and adds to the allied group an establishment where one of the most terrible of human afflictions may be scientifically examined and treated.

Today the cornerstone is to be laid. So important is the step that the Governor, recognizing that he can do no higher duty, comes to us to lay the stone himself. But he is to do more than set a stone. He is to fix a foundation whereby sufferers can be rescued from the awful darkness of a living death, and be restored to the sunshine and brightness of an unclouded, happy, useful life. What a splendid and inspiring contribution to our joint aim! The Governor has done great things but none with more noble purpose than the one he is about to perform today.

On behalf of the Joint Administrative Board, representing Columbia University the several associated hospitals, I greet and bid hearty welcome to the State and pledge to it our intellectual and scientific resources in research, teaching and practice to aid the State so far as we can in the lofty work it is undertaking. And to you, Governor, I tender the appreciation of all my colleagues in this great enterprise. I now as you, Sir, to lay the cornerstone of the State Psychiatric Institute.

Governor Smith then laid the cornerstone, following which William O. Ludlow, Chairman of the Committee on Recognition of Craftsmanship of the New York Building Congress, made a brief address expressing appreciation of the work of State Architect Jones and of the various craftsmen engaged in constructing the building. At the conclusion of the address he requested Governor Smith to present certificates to the following workmen: Samuel K. Newell, stonesetter; George Marsh, waterproofer; Peter Hanson, structural ironworker, and Andrew Cardinale, rockdriller.

ADDRESS BY GOVERNOR SMITH

Mr. Chairman, Fellow Citizens: The building that we are today dedicating by the laying of its cornerstone is being built from the prooceeds of the so-called $50,000,000 bond issue authorized by the people of the State at the election in the fall of 1923. The purpose of that referendum was to secure ready money from the sale of bonds in order to lay out a definite, fixed program over a period of four years for the erection of buildings for the care of the wards of the State, exclusive of those in penal institutions or reformatories. The whole $50,000,000 at the rate of $12,500,000 a year has already been allocated and 66 per cent of it was assigned to the construction and betterment of the buildings that are housing the mentally sick and afflicted wards of the State.

Prior to 1890 the care of the insane was principally a county function, and people suffering from mental disease found their way into what was then referred to as the lunatic asylum. Counties that did not maintain asylums for the care of the insane were obliged to send them to almshouses, poorhouses and we have some record of where they were sent even to penitentiaries.

In 1890, however, the State took over from the counties the function of caring for the insane and to the end that it may never be disturbed without vote of the people that policy was incorporated in the Constitution adopted in 1894 when there was set up the State Commission on Lunacy, afterwards changed to the State Hospital Commission, and now by constitutional amendment referred to as the Department of Mental Hygiene.

I take it that the people of this State if they take upon their shoulders by their own vote the solemn responsibility of caring for these unfortunate insane people that they intend to do it as close as they possibly can to one hundred per cent of the afflicted.

I believe that the care of the insane is probably as large a problem as we have to deal with today, for the reason that it is constantly growing. In ten years the total appropriations from the general fund for the institutions in the Department of Mental Hygiene increased from $12,400,000 to $24,400,000 a year. Entirely outside of bond issue money, entirely outside of money appropriated for fire prevention purposes in some of the old buildings that we took over from the county, we have expended for such institutions this year close to $24,000,000.

This problem of the care of the insane is one that I think is going to engage our attention for some time to come. If we were compelled by law to accept the feebleminded, as we are by law compelled to accept the insane when they are committed, fifty or one hundred and fifty million dollars would not begin to scratch the surface of that problem.

On the first of July there were 47,000 people in the hospitals for the insane alone.. If we could stop there the problem would not be so difficult, but in the last calendar year we have had admitted close to 1,900 people, over and above deaths and discharges.. That is additional population the State is compelled to deal with.

Men that are in a position to know, the doctors, the men who have made a study of it, are all certifying that after you get above a population of 4,000 in one hospital it is difficult to do anything for the patient; it is difficult to centrally administer to the needs and wants of more than 4,000. When you add to that 1,500 of necessary help every new hospital is practically a small village. Now, of course, it needs no explanation to say that these hospitals cannot be built in the city. They require acreage and they must be built out in the country, Well, what does that mean? That means that when we start a new hospital we set up a village of 5,000 people. We have not only to build a building, but we have to find a water supply; we have to build sewage disposal plants; we have to provide electrical energy, light and heat, and power for an enormous group of buildings.

The new Rockland State Hospital projected at Orangeburg, New York, for which institution I broke ground in the month of July, will cost the people of this State ten and one-half million dollars without spending a single dollar for equipment. That is the cost of the buildings themselves—ten and one-half million dollars.

If these patients are to increase at the rate of nearly 2,000 a year, that means a new hospital every two years, or else overcrowding in the existing institutions will grow beyond the point that it now exists, and the Lord Himself knows it is bad enough now.

That means in dollars and cents, without taking into account equipment, at least $5,500,000 a year just to meet the constantly rising growth.

Now, if that 1,900 increase of this year was extraordinary it probably would not give us quite so much concern, but there has been a marked increase annually, for many years. It had never been above 1,500 in any year, but this year it reached the peak when it was so close to 2,000 patients.

I regard this structure as being erected from the standpoint of the citizen, not only as the State's contribution to the betterment of humanity, but as distinctly an economical step because it is up to the State of New York to do everything it can to prevent disease by delving into its causes to the end that we will not be compelled to take care of people after they become afflicted, but try and help them before that time. (Applause.)

So that, I might say, is in the interest of greater economy for the State of New York. The plans are now being prepared for a similar institution in the City of Syracuse, to take care of the central and western part of the State. Land will be purchased in an adjoining county within a few months

for an additional new State hospital. At Kings Park, the Veterans' Memorial Hospital will be opened by me on Saturday. Creedmoor is ready for occupancy about the first of October. Creedmoor will bring relief to the Metropolitan District. These hospitals must be planned to serve the population where they are most needed, and the Metropolitan District is today suffering the greatest overcrowding.. There are altogether too many patients on Ward's Island.

Aside from our new institutions, let us think for a moment of the question of the old ones that have outgrown their usefulness. Up in Utica the old Utica State Hospital, the first one owned, and the only one operated by the State prior to 1869, was built in 1843. The administration building on Ward's Island where the fire occurred was used as a home for emigrant girls as far back as 1853. Some of these old hospitals are in very poor condition. On some we are spending more over a period of years for repairs and replacements than the property is worth as it stands today. As a business proposition it would be infinitely better that we get rid of all the old dilapidated fire traps and set up a chain of hospitals befitting the dignity and the power and the wealth of the greatest State in the Union. (Applause.)

Commissioner Folks in the course of his remarks gave me altogether too much credit. I will always cherish the trowel and the pictures of the laying of the cornerstone, and in the years to come if the cornerstone is ever disturbed there will be found in it a copy of my message to the Legislature on this bond issue. That is glory enough for me. But I want to say to this assemblage today if it had not been for the assistance of Commissioner Folks and the Citizens Committee that I gathered about, it might not have been so easy to sell to the people of the State the notion that they should approve of a bond issue of $50,000,00 when we were practically without a program except that which was laid down as indicating the existing conditions that we had in our minds to cure.

The Legislature and the people have also voted $10,000,000 a year of bond money for other public improvements. It was the hope of the framers of that resolution that a large part of that could go to the State hospitals for the care of the insane. But the needs of the State are so great, there are so many other institutions, like the prisons, like the schools for the mentally deficient, not comprehended to any great extent within the $50,000,000 bond issue, prisons not at all, that it is extremely doubtful whether even with the present appropriation, unless it is supplemented annually by large appropriations from the current revenues of the State, we would be able to keep up with the present growth in the State hospitals.

However, that is a matter that we will deal with at a later date, after we see the allocations of money over a number of years from the proposed bond issue.

I want to express my personal and individual satisfaction at seeing this building going along as fast as it is. It certainly is gratifying to me personally. I congratulate my fellow laborers who have received these wards and the State Architect, the Commissioner of Mental Hygiene and all the men and women that have in any way contributed to what we have come here today to look upon with so much satisfaction, and I cannot let a thought escape me as we leave this building. It is in my mind, I cannot get away from it, and I think you should have it too: Aside from the economic question, aside from the matter of State duty, aside from the matter of constitutional obligation, I regard a building of this kind as an act of Thanksgiving to Almighty God Himself who has been particularly good in His infinite wisdom and His infinite kindness to the people of the State of New York. (Applause.)

DEDICATION OF THE VETERANS' MEMORIAL HOSPITAL DIVISION OF THE KINGS PARK STATE HOSPITAL

The dedication of the new Veterans' Memorial Hospital which took place at Kings Park, September 24, 1927, constitutes one of the most important events in the history of the State hospital system. Governor Smith had planned to make the dedicatory address but illness prevented his attendance. He, however, sent a letter which was read by the chairman and appears as a part of the ceremonies given below. He also sent Major General William N. Haskell, commander of the New York National Guard, as his representative.

The ceremonies were held in the plaza in front of the large medical and surgical building, the heart of the new hospital, and were attended by about 2,000 persons including representatives of many organizations and distinguished guests.

Hon. Matthew J. Tobin, chairman of the Board of Visitors of the Kings Park State Hospital, presided.

PRAYER BY RABBI LOUIS D. GROSS

Lord God of all mankind Thy blessing we invoke, for Thine are the power and the glory and the love; the truth and the beauty, the might and the majesty. For Thine untold bounties we praise Thee with hearts overflowing with gratitude even as we thank Thee for the precious gift of this day dedicated unto Thee in behalf of the weak as well as the strong; in behalf of the noble souls, who struggled and strove and suffered that we might live and find happiness. Preside Thou Oh Father over this assembly that here the spirit of love and harmony and good will may prevail. May Thy blessing abide with us.

With all who are here from far and near to participate in this feast of dedication and by their presence to testify to their faith in the spiritual values of life, expressed through works of mercy and justice and fellowship, cause the lesson of this day to sink deeply into our hearts, make us to learn that our prayers and our pieties, our religions and our theologies are futile and of no avail in Thy sight if they be not translated into an exalted, helpful, healing blessedness.

Oh God bless the noble Governor of our great State through whose wise and benevolent efforts, through legislation, untold good has been achieved in behalf of humanity. Continue him in the gifts and powers with which Thou has endowed him as the great leader that he may yet go forward in strength and glory to newer and higher conquests.

Bless the words spoken here today. May the message brought to us fall

ADMINISTRATION BUILDING, VETERANS' MEMORIAL HOSPITAL AT KINGS PARK

like seed on fertile soil whence shall spring the full blown flower of love and duty of service and devotion for the sake of Thy children, in behalf of a finer and a nobler, a stronger, a more vigorous, a more rejoicing humanity. Amen.

Guests Welcomed by Chairman Tobin

Ladies and Gentlemen, Honored Guests and Members of the American Legion: The Kings Park Board of Visitors, the Superintendent and the Staff extend to you all a very cordial welcome and hope before the day is over that you will avail yourselves of the opportunity of visiting and inspecting our new buildings about to be dedicated. All of the points in connection with these beautiful buildings will be covered by the speakers who are about to follow.

I will confine myself strictly to the formal program, but before proceeding to the next speaker I have a letter of importance which I desire to read.

Letter from Governor Smith

Mr. M. J. Tobin, *Chairman,*
Dedication, Veterans' Memorial Hospital,
Kings Park, L. I.
Dear Mr. Chairman:

May I express my extreme regret that a slight bronchial attack prevents my coming to Long Island today.

I know of nothing that I would rather have done than dedicate the Veterans' Memorial Hospital. I was present, as you remember at the ground-breaking ceremony and turned the first spadeful of earth and it has all along been a project very dear to me.

The significance of this occasion is not only that we have built a splendid memorial to those veterans to whom we can never pay our debt of gratitude, but also that it is the final completion of the first of the great institutions that are being built out of the hospital bond issue voted by the people of the State of New York.

It further illustrates one of the arguments which I made for the passage of this bond issue, because this project was twice abandoned when it was to have been built from current revenue and could not possibly have been created without the hospital bond issue.

This building stands, therefore, as a monument both to the patriotism and devotion of our veterans and to the patriotism and good sense of the electorate of the State of New York.

Very truly yours,
(Signed) ALFRED E. SMITH.

ADDRESS BY GEORGE F. CANFIELD

President of State Charities Aid Association

It is a great satisfaction to me, as president of the State Charities Aid Association and as a member of the Citizens Committee, for the Protection of the State's Unfortunates, to take part in this ceremony of dedication of the Veterans' Memorial Hospital. It is an interesting and important occasion both on account of the accomplishment, which we have come together today to celebrate, and also on account of the way in which that accomplishment has been effected.

It is now nearly 40 years ago, to be exact 37 years ago, since the State of New York assumed the care of its dependent insane. It was a great responsibility and it was assumed not without some doubts and misgivings and some strenuous opposition and not without having to overcome opposition. A spirited campaign of advocacy and appeal was conducted by the State Charities Aid Association under the able leadership of a great woman, Miss Louisa Lee Schuyler. But whatever doubts may have existed as to the soundness of the policy of State care of the insane there has never been any doubt and there can be no doubt that it is the duty of the State, except of course as far as the Federal government assumes the responsibility, to care for the mentally afflicted among our ex-service men. Those who have offered their all, who have been willing to lay down their lives for their country and have suffered a mental breakdown from the strain and horrors of war deserve and must receive the loving care and attention of those who have benefited by their sacrifices.

In recognition of this duty the State in 1923 appropriated $1,500,000 toward the cost of accommodations for the insane among our ex-service men. This sum was of course entirely inadequate and we should not be here today but we should have to confess that we had miserably failed in our duty towards these disabled veterans, if the State had not authorized the $50,000,000 bond issue, to which the Governor refers in his letter, a part of which has been used for this institution.

Governor Smith, a sincere philanthropist, upon whom the social workers of the City of New York bestowed this year a medal for social service, a rare and unusual honor, long ago perceived that it would be impossible to care for the State's dependents, the State's unfortunates, out of current annual revenues. He perceived that the State care of the insane would be entirely inadequate care if only the current revenues were available for that purpose. For, in spite of a very excellent administration of our State hospital system and no administrative work of the State of New York has been better performed than that of the State Hospital Commission and the super-

intendents of our State hospitals. In spite of approved methods of treatment, in spite of the system of parole and after-care, the overcrowding of our hospitals has gone on from year to year and within recent years at an accelerated pace and to an alarming extent.

The Governor therefore proposed that the State should be authorized to issues $50,000,000 of bonds, twelve and one-half million ($12,500,000) to be sold in each of four successive years, to provide the necessary funds and, at his suggestion, the State Charities Aid Association appointed a committee of citizens, to which I refer and from which I have a memorandum to him asking him to bring the matter to the attention of the people and advocate its adoption. This work was so well done that in the year of 1923 the proposal was adopted by an unprecedented majority. And after the approval of the bond issue this same committee, at the suggestion of Governor Smith, cooperated with the public officials in formulating a program for expending the proceeds of these bonds and this work was so well done that all these proceeds were expended solely for the objects for which they were intended. There was no log rolling, no diversion of funds for partisan political purposes, no diversion of funds as I say, but the whole of the $50,000,000 was expended or appropriated economically, a very notable and commendable achievement.

Out of the $50,000,000 of the bond issue there has been allotted or appropriated, in two separate allotments for the Veterans' Hospital an aggregate amount of $2,400,000, and Governor Smith, whose absence we all regret—I can't help thinking if he had been here he would be benefited by the glorious sunshine and air, by the presence of these people gathered here and by the completed buildings, evidence as to the soundness of the policy for the State care of the insane and of the bond issue making that policy effective. And these splendid buildings we may hope will stand long beyond the life of the bonds as excellent testimonies that republics are not always ungrateful, that they are not always unmindful of their duties and responsibilities and that with sympathetic, trustful cooperation between officials and private citizens large sums of money may be expended for legitimate public purposes honorably, conscientiously, economically and wisely.

Finally, if I may be permitted one more word, these buildings, this Memorial Hospital, should serve another useful purpose with its accumulation of human wreckage. It should be a constant reminder of the grim horrors of war and should stimulate us all, each according to his abilities and opportunities, to promote understanding and goodwill among the nations of the earth, the most essential foundation of world peace.

ADDRESS BY ALMON G. RASQUIN,

Department Judge Advocate of the American Legion

We regret exceedingly that the message of the American Legion today cannot be delivered to you by our State Commander but, as many of you know, he is now in France engaged upon another solemn duty, that of leading a number of our members upon their sacred pilgrimage to the graves of our departed comrades who made the supreme sacrifice and now lie buried over there. In his absence I shall endeavor to deliver the message as we have it.

Today is one of gratitude, pride and renewed pledge. We are exceedingly grateful for the invitation to participate in this ceremony. Whenever we are invited to attend a public function, which in itself proves conclusively that the glorious sacrifices of our former comrades in arms are fully recognized by our fellow citizens, we are indeed happy and anxious to respond and we are always glad of the opportunity to publicly express our praise in testimony of a worthy deed well done. By reason of our organization and the principles of its existence, by reason of our past association with those valient heroes to whose welfare this wonderful edifice is to be dedicated and because one of the foremost purposes of our organization obligates us to the care and rehabilitation of our disabled comrades, we are happy to be here today and consider that we are privileged to represent and speak for them on an occasion such as this.

The great war produced no problem more serious and difficult than the hospitalization and rehabilitation of its disabled veterans. Natural economic conditions and progress and private enterprises can eventually reconstruct the affairs of industries, commerce, government and all other similar elements of a national existence but the reconstruction of the human bodies and minds of such a vast number of beings as that war necessitated can be accomplished only by the government through efficient administration at the direction of its people. And while no less attention can be paid to other disabilities the greatest problem and obligation is the restoration of the mental faculties. Were all the unfortunates to be merely classed insane, without distinction as to degree, and were shelter from the elements and necessary food and sustenance its only problem the task would be simple but where science has established that mental ailments exist in a number of different ways and in a number of cases can be relieved and in a number of cases cured, a Christian nation, by its wealth and knowledge, is charged with the rehabilitation of its mentally disabled veterans, who fought its battles, to the extent of its resources.

Our Federal government has made wonderful progress in this work. Congress has faced the problem each year with a full realization of its respon-

sibilities. It has been our privilege to cooperate in this undertaking and our suggestions and even demands have been received with an attentive ear. But the problem is too large for Federal control alone. The requirements are too far-reaching. The mentally afflicted need the care and personal attention of relatives and friends as well as frequent governmental supervision. Their intimate personal welfare must be considered, their properties must be preserved, their estates must be administered and safeguarded from waste and this can be accomplished satisfactorily only in the vicinity of their homes, where the men have their relatives and friends, which will permit of that personal attention.

Our great State of New York was among the first to grasp this important feature. Under the wise and efficient administration of our present Chief Executive and his able departmental heads, our State has taken the lead in this wonderful service to humanity and today stands out as a shining example to the world in the cause of human welfare.

The American Legion has been permitted to cooperate in the progress of this undertaking. We have proudly watched the fulfillment of these obligations by our fellow citizens. We have with pride and deep appreciation observed the untiring efforts of our able Governor, than whom the disabled veteran has no better friend, and we exceedingly regret today the illness which prevents his dedicating in person this wonderful memorial in which he is so deeply interested.

I recall very vividly the great volume of applause which greeted Governor Smith at our convention a year ago when informing us of this project. He said, "Over a thousand young men, who returned from France, are scattered about in 12 or 13 hospitals. It is the desire of the State to bring them all under one roof where special care and special treatment can be accorded them and, if it is possible, to effect a cure so that the State may be able to be in a position to say at least that she did every human and possible thing she could to cure them." That trust was thus accepted by the people of this State and the American Legion is here today to testify on behalf of these disabled comrades, that this Empire State through its administrative agencies has kept solemn faith with them. Therefore my friends, representing 63,000 of your fellow citizens, legionaires and veterans, comrades of those to whose service and welfare this glorious tribute is to be dedicated, it is a distinguished privilege and pleasure for us to publicly acknowledge and proclaim that as we are proud of our service, which gave us our organization, as we are proud of our comradeship with those heroes so are we proud of our fellow citizenship with you in this great sovereign State that has so nobly, ably and generously entered upon the fulfillment of its trust and obligation. As you have thus kept faith with them we reiterate to you a portion of our pledge, set forth in the preamble of our Legion constitution,

"To inculcate a sense of individual obligation to the community, State and nation, to safeguard and transmit to posterity the principles of justice, freedom and democracy and to consecrate and sanctify our comradeship by our devotion to mutual helpfulness."

Address by Dr. Frederick W. Parsons, Commissioner of Mental Hygiene

On the record of fine deeds done by the State of New York will be written large the fact that a grateful Commonwealth built and equipped one of the finest and most complete hospitals of its kind. The State today dedicates it to its high purpose, that of caring for such of its citizens who responded to the Nation's call and now suffer. That the establishment of this hospital was a gratuitous act is to the State's greater credit for it might have said that its citizens, by entering the United States Army, were and are the wards of the Nation. This State of ours did not take that stand but gave liberally and this Veterans' Unit is the result. She built a hospital the like of which cannot be found and we stand at the portico of one of the buildings of that group today unveiling a tablet of commemoration.

As the spokesman of the Department of Mental Hygiene a solemn obligation is placed in my keeping. I am to make good the expressed wish of the State—to translate into service the will of the people and to give to the future patients of this unit, care of a standard never before attempted by the citizens of this State.

An unhappy situation prevents Governor Smith from voicing his sentiments in respect to what he conceives to be the duty of the State but those of us who know of his sympathies for the unfortunate realize his intentions concerning this structure and it remains for the department of Mental Hygiene to meet those views. That is the wish of a grateful people which intends that the resources of the State shall be devoted to the needs of the men and women who heard a call, answered and now pay a price. What I consider to be the wishes of the people is that the men and women who find refuge in these buildings receive all that a rich and powerful and likewise grateful State can bestow. The patients of this hospital deserve no less and that they shall have.

Address by Monsignor York, Member of Board of Visitors, Kings Park State Hospital

Before uttering a dedicatory prayer I may be permitted to make a few remarks on the history of the hospital. I remember its establishment as an overflow from the old Kings County Insane Asylum on Clarkson Avenue, Brooklyn, in 1886. It was a county hospital, as all others throughout the State were at that time. Not until the early nineties did it become a State

COMMISSIONER PARSONS SPEAKING AT THE DEDICATION OF THE VETERANS' MEMORIAL HOSPITAL AT KINGS PARK

hospital. And the one responsible for the State's taking over the county asylum was a noble woman, Miss Louise Lee Schuyler. She, single-handed and alone, aroused the interest of a small group of influential people to agitate for State control, and she won her cause. The old county system with its graft, cruelty and gross mismanagement passed forever. * * * *

Governor Smith has done the miraculous for the welfare of the insane. It was his inspiration and courage which put over the great bond issue of fifty millions of dollars a few years ago. He aroused the people from their lethargy and made them overlook the slight raise in State taxation which the issue would entail. We regret that sickkness keeps him away today. We pray for him, "The Lord bless him and give him life and make him blessed on earth and deliver him not into the hands of his enemies."

Like the brilliant sun shining over us attracting our gaze, so the brilliant deeds of Governor Smith, attract friend and foe alike throughout the Nation. And people who once misunderstood him and misjudged him and were bigoted towards him now see that he is a real human whose big heart goes out in sympathy to every case of distress.

And now we offer these buildings to Almighty God and ask Him to bless them and all who are housed here and all who labor here. They were His from the beginning, the elements which enter into them, the stone, wood, cement, iron, all are the Lord's, for "the earth is the Lord's and the fullness thereof." All men had to do was to assemble these elements into dwellings under the guidance of our State Architect, Mr. Sullivan W. Jones.

May Christ send the spirit of healing, of mercy and of patience on all who will minister here to the afflicted. May no one entering here leave hope behind, but entering in one door may leave through the other, sane and sound.

The tablet was then unveiled by General William N. Haskell, Commander of the New York National Guard, acting as the representative of Governor Smith.

ADDRESS BY GENERAL HASKELL

I feel very proud and highly honored in speaking to you today at such a glorious ceremony. I am happy to be here and only regret that Governor Smith is unable to be present and join with you on the auspicious occasion of dedicating this Veterans' Memorial Hospital and see the fruit of his labors.

Naturally you are all disappointed that the Governor is not here in person today, but you may be sure that he is here in spirit. This public work is very near to his heart as are all those which look to the care of the unfortunate charges of this State.

I wish that you could know and see as I have seen from one end of the

State to the other, the accomplishments of this man that I represent here today. Everywhere in this State that we love so much, is evidence of his battle for better and adequate care for the poor, the sick, the weak, the defectives and the feeble-minded. How proud the citizens of New York should be of themselves for coming at last to the realization of their responsibilities in this respect. How proud they should be of the leadership that brought about and is bringing about in this State a proper regard for their own unfortunates.

I have recently been privileged to see many State institutions rising from the ground as mute but living testimonials of a consciousness awakened to a sense of responsibility.

Yes, money has been spent for these institutions, but we are richer in self-respect—and what more appropriate expenditure can be cited by any government than the decent care of its own people. That is a primary obligation of government.

We are a rich State—the richest State—should we not fulfill our moral obligations? Expenditures for adequate public institutions will never be seriously or successfully attacked. Where there is no wasted money, reasonable citizens will always approve intelligent vision and action, whether it be for new roads, prisons, hospitals, bridges, tunnels or for safety conditions for the public.

It takes vision to see and plan for the future, but courage of the highest order to carry such works to success. The people of this State need no longer hang their heads in shame when contemplating their own public institutions.

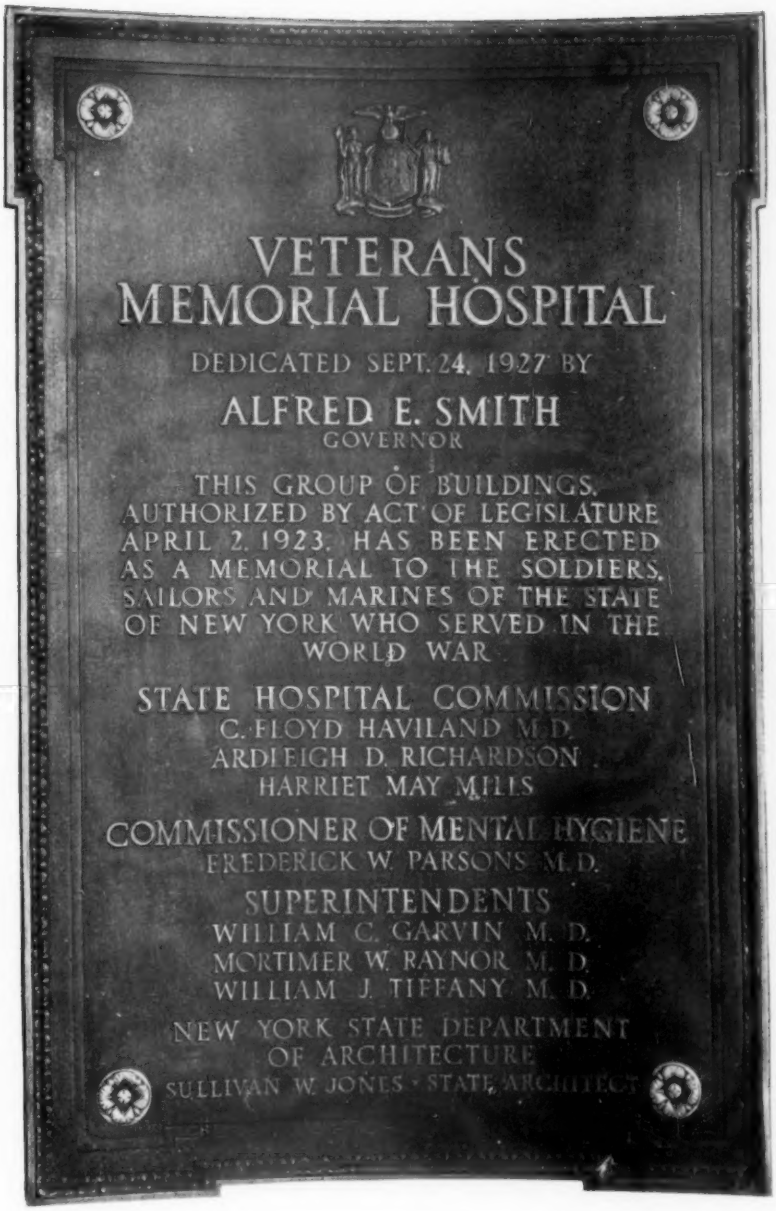
And here today is still another evidence of meeting our obligations.

I am especially interested in this particular institution because I have had the opportunity and the great honor to know intimately those courageous men from whom the inmates of this hospital will be drawn. Ladies and gentlemen, nothing could be too good for them. I saw them answer the call of their State and Nation, I saw the sadness of the disintegration of families, I received over 40,000 into Camp Upton not many miles from here; I saw them overseas, I saw them killed, wounded and mentally broken. No finer example of courage and sacrifice was ever given—no greater contribution of citizenship.

In a measure we are today trying to express the appreciation of a debt to those men that never could be paid.

As I look around, I wonder how long the people of this State would have waited if this most complete institution of its kind ever built should have depended and waited on current revenues. Probably beyond the lifetime of the generation which it was primarily designed to serve.

First proposed to the Legislature in 1920 by Governor Smith and then


VETERANS
MEMORIAL HOSPITAL
DEDICATED SEPT. 24, 1927 BY
ALFRED E. SMITH
GOVERNOR
THIS GROUP OF BUILDINGS,
AUTHORIZED BY ACT OF LEGISLATURE
APRIL 2, 1923, HAS BEEN ERECTED
AS A MEMORIAL TO THE SOLDIERS,
SAILORS AND MARINES OF THE STATE
OF NEW YORK WHO SERVED IN THE
WORLD WAR
STATE HOSPITAL COMMISSION
C. FLOYD HAVILAND M.D.
ARDLEIGH D. RICHARDSON
HARRIET MAY MILLS
COMMISSIONER OF MENTAL HYGIENE
FREDERICK W. PARSONS M.D.
SUPERINTENDENTS
WILLIAM C. GARVIN M.D.
MORTIMER W. RAYNOR M.D.
WILLIAM J. TIFFANY M.D.
NEW YORK STATE DEPARTMENT
OF ARCHITECTURE
SULLIVAN W. JONES - STATE ARCHITECT

authorized, the next administration dropped it only to have it revived and sponsored again by the Governor on his return to office.

Lack of appropriations then blocked action and finally the bond issue, authorized by an intelligent electorate conscious of their civic responsibilities, made possible the conclusion of this magnificent institution at a cost of nearly four million dollars—every dollar of which was honestly and wisely spent.

Here we can point with pride to a noble work, nobly and efficiently concluded.

This then marks the completion of the first great work from the hospital bond issue. It was started in 1923 and it is dedicated in 1927. That is the best answer yet given to the question "Bond issue or current revenues."

No intelligent person is misled into dreaming for a moment, that anything but the bond issue is responsible for this wonderful accomplishment. To divert a moment, I might add that the same lesson is being taught daily through the rapid progress of other most urgent public works now going forward under the one hundred million dollar bond issue.

I know that others besides Governor Smith have shared with him the glory of this accomplishment and if the Governor were here he would not fail to pay high tribute to the late Dr. Thomas W. Salmon, who unfortunately, was not permitted to live to see this work completed.

He, who was responsible to so great an extent in planning and carrying out the plan, must look down upon us here today with a great sense of satisfaction. We, who were in France, knew him well for his great service there and now all honor to his continued service to his beloved veterans here.

May I also express the appreciation of the Governor (representing all the people of this great State) to the "Citizens Committee for the Protection of the State's Unfortunates," as represented here today by Mr. George F. Canfield and which so ably assisted in passing the bond issue amendment.

Much credit is also due to the hospital authorities at Kings Park, the State Architect and other State officials concerned in the construction of these buildings as well as the eminent psychiatrists who so generously gave their time, advice and encouragement.

In conclusion, permit me on behalf of Governor Smith to dedicate this great institution to the service of the people of the State of New York in grateful acknowledgment of the heroic sacrifices made by our citizens in the great war.

BENEDICTION BY REV. HARTLEY J. HARTMAN,
Chaplain of the Nassau County American Legion

Almighty God, our loving heavenly Father and the Father of all mankind, we pray the benediction of Thy holy presence upon this institution here dedicated to this service for our suffering soldiers. May Thy presence,

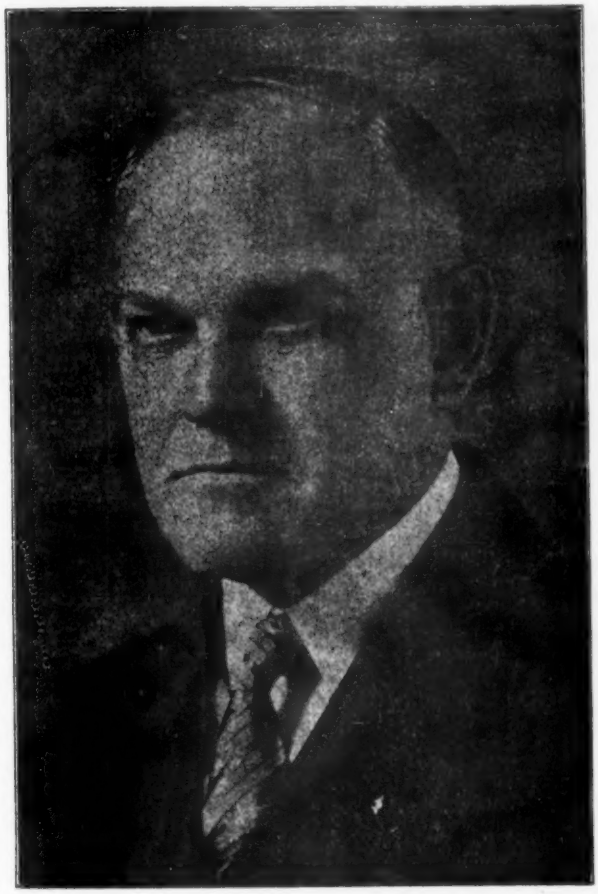
abiding here in this institution, govern all the ministry of healing that Thou dost now commit into our care and especially into the hands of Thy servants, the physicians and nurses who here for us shall serve them. May that presence of the One who is known as the healing Master bring its grace of service to bear on the healing of the minds and the hearts of those who are here to be cared for and as long as time shall last, may this place be a perpetual memorial to the loving care which we have for one another in time of disaster and sorrow, particularly when they result from such noble service as those gave who pledged their last full measure of devotion that we might have life and liberty and happiness. Amen.

Following the benediction the flag was raised on the new flag pole. The new buildings were then inspected and a buffet lunch was served in the administration building.

DR. VAN DE MARK APPOINTED SUPERINTENDENT OF ROCHESTER STATE HOSPITAL

Dr. John Lewis Van DeMark, medical inspector, was appointed by Commissioner Parsons superintendent of the Rochester State Hospital, September 16, 1927. He succeeds Dr. Eugene H. Howard, who died August 24, 1927.

Dr. Van DeMark was born on a farm in Seneca County, New York, March 10, 1879. His early education began in a district school. Later he attended the Waterloo schools and was graduated from the high school in 1897. For three years following graduation he continued on the farm. He entered medical school at the University of Buffalo in 1900 and was graduated with the degree of Doctor of Medicine in 1904. After serving one year as interne in the Erie County Hospital in Buffalo, he entered State service at St. Lawrence State Hospital in February, 1906. He remained at St. Lawrence State Hospital until April, 1911, passing through the grades to and including assistant physician. Following this he was in private practice for a short time. He took a three months' course at the New York Post-Graduate Medical School in 1912 and



re-entered State hospital service at Central Islip on August 1 of that year. He was transferred from this hospital to the Bureau of Deportation on May 1, 1913, becoming deputy medical examiner. He was promoted to medical examiner in charge of the Bureau on September 1, 1916, but owing to unusual circumstances during this period, he was detailed a large part of this time as acting medical inspector. He was appointed medical inspector by civil service transfer on May 1, 1919, and served in this capacity until October 1, 1921, when he was transferred to the position of first assistant physician at the Rochester State Hospital. He was again appointed to the position of medical inspector in the Department of Mental Hygiene, August 1, 1927.

During Dr. Van DeMark's connection with the State hospital service he has had two courses at the Psychiatric Institute. While serving at St. Lawrence State Hospital he became a member of the County and State Medical Societies and since then has become a member of the American Psychiatric Association, the American Medical Association, Rochester Medical Association and the Neuron Club of Western New York. For some years he has been a member of the Masonic fraternity.

On February 3, 1915, he was married to Dora M. Fuller and has two children, Helen Elizabeth and Robert Lewis.

APPOINTMENT OF DR. RICHARD H. HUTCHINGS, JR., AS DEPUTY MEDICAL INSPECTOR

Dr. Richard Henry Hutchings, Jr., senior assistant physician of the Utica State Hospital, was appointed by Commissioner Parsons, deputy medical inspector, September 12, 1927. The new appointee is the son of Dr. Richard H. Hutchings, superintendent of the Utica State Hospital, and was born at Ogdensburg, N. Y., September 19, 1894.

Dr. Hutchings, Jr., was graduated from Syracuse University with the degree of Bachelor of Science in 1917, and from the Syracuse University College of Medicine in 1919 with the degree of Doctor of Medicine.

While in medical school and for a year after graduation Dr. Hutchings was assistant roentgenologist in the Syracuse Free Dispensary. He was also in private practice in Syracuse from 1919 to 1920. On May 1, 1920, he was appointed medical interne in Utica State Hospital and on July 1 of the same year was promoted to assistant physician, and was for a time the only medical officer stationed at the Marcy Division. On February 15, 1923, he was promoted to senior assistant physician and served in this capacity up to the time of his appointment as deputy medical inspector. He is a member of the New York State Medical Society, the Oneida County Medical Society, the Radiological Society of North America, Central New York Roentgen Ray Society and the American Electro-Therapeutic Association. While in Syracuse University he was a member of the Zeta Psi and Nu Sigma Nu fraternities.

DR. HENRY M. HURD

Dr. Henry M. Hurd, author, psychiatrist and hospital administrator, died July 19, 1927, at the advanced age of 83 years. For many years he was a recognized leader among State hospital superintendents, and through his writings made a notable contribution to the advancement of the care of the mentally diseased in this country.

Dr. Hurd was born in Union City, Mich., May 3, 1843. He graduated from the University of Michigan with the degree of A. B. in 1863. He then entered the medical school of the same institution and received his doctor's degree in 1886. He was superintendent of the Eastern Michigan Asylum at Pontiac from 1878 to 1889, and superintendent of the Johns Hopkins Hospital from 1889 to 1911. While occupying the latter position he was professor of psychiatry of the Johns Hopkins University for 17 years. He also edited the Johns Hopkins Bulletin and hospital reports from 1890 to 1911. He was one of the editors of the American Journal of Insanity from 1897 to 1920 and editor of Modern Hospital from 1913 to 1920. Perhaps his most enduring work was the preparation of the "Institutional Care of the Insane in the United States and Canada," consisting of four large volumes.

The following quotation from a fitting tribute by Dr. G. Adler Blumer gives a glimpse of the rare qualities of this remarkable man.

"He brought to bear upon every task a rare combination of literary and executive talent and all-around equipment in performing his duties. His was that admirable balance of qualities of mind and character that made for adequacy to any work which as editor he was called upon to do. His experience was "the light of a lantern set in the stern of a boat, illuming the path we leave behind us." His judgment and taste, based upon a long and varied knowledge of men and affairs, could always be trusted. Given a cause that commended itself to his wisdom, no man ever sought his friendly counsel and went empty away. He was ever tolerant because his catholic mind was responsive to every phase of truth. He put the end before the means and the whole above the part.***** He pursued with relentless energy and steadiness all the good and useful things—and how many and various they were!—which he was so easily capable of doing, faltering not even in his weariness when age and infirmity overtook and beset him."

EUROPEAN METHODS AND IDEAS OF PENAL TREATMENT

Dr. Louis N. Robinson, secretary of the Sub-Committee of the National Crime Commission on Pardons, Parole, Probation, Penal Laws, and Institutional Correction, has recently submitted a report of his investigation of methods used in Europe in dealing with convicted offenders. The following excerpts from this report are significant in indicating the present tendencies in Europe with reference to the prevention and punishment of crime.

"Though there is no let-down in Europe in the general attempt to make punishment for wrongdoing swift and certain, the thing that strikes one's attention is the absence of any tendency to turn to more severe penalties or to a harsher regime in the effort to stamp out crime. Everywhere there is manifest a movement to soften the asperities of the penal law and to mitigate the former harshness of prison discipline. The long sentences recently imposed by certain American judges are regarded by European students as a return to the cruelty of the Middle Ages, and a further increase in the barbarities of our prisons is difficult to explain to those Europeans who have in the past looked to America as the birthplace of new ideas with respect to the worth and dignity of all members of mankind.

"The question will now be asked: On what do European countries rely to keep down crime? Leaving out of account those social ameliorations of which we are all, both Europeans and Americans, fully conscious as tending to lessen crime, I would say that the main reliance is on the police. In other words, while we Americans seem to think that crime can be held in check by punishing severely an insignificant fraction of our criminals, Europeans believe that it is far more effective to impose reasonably mild penalties on a large proportion of those who offend. A short time ago, an investigation in two of the leading cities of Missouri revealed the fact that whereas information had been laid before the police concerning some fourteen thousand major felonies, arrests had followed in only eight per cent of the cases. Worse—it was shown that a total of only three per cent had been found, or had plead, guilty. To trust in the efficacy of punishing severely the three per cent while allowing the ninety-seven per cent to escape scot-free would scarcely appeal to a European as an example of our boasted efficiency or our hard common sense. They, on the contrary, have built up non-political police forces that make it decidedly risky for an individual to engage in crime.

THE VALUE OF PUBLICITY

It is worthy of note that prominent and influential newspapers throughout the State are manifesting in their editorial and news columns keen interest in the problem presented by the recent marked increase in the number of

cases of mental disease in public and licensed private institutions and in the efforts put forth by public and private agencies designed to help solve the problem.

To what extent this publicity can be held responsible for the increase in the number of cases is perhaps debatable. It will not be surprising if ere long the subject is given consideration by psychiatrists of inquiring minds who specialize in seeking the causes which produce the effects.

It is no doubt true that because of newspaper publicity the State hospitals for the care and treatment of the mentally diseased have become more widely and more favorably known among the people of the State and that because of this increase in public confidence the mild cases which formerly were cared for at home are now being sent to institutions where they receive better care than the average home can provide. To this extent and in this particular, publicity may be held somewhat responsible for the increase in the number of admissions to institutions. It is doubtful however, whether publicity, the chronicling of news about mental disease and editorial comment thereon, and the reading and consideration of the same by newspaper readers, can be held responsible for manifestations of the disease in the first instance in consequence of any psychological effect produced by such publicity upon readers.

Recent publicity has been both intelligent and informative. It has been inspired by public utterances of Governor Smith and Commissioner Parsons of the Department of Mental Hygiene and public events related to the State's activities in the field of psychiatry. The spirit of helpfulness has been manifest. There appears to be on the part of both editorial and news writers a sincere desire to assist in checking the disease by disseminating information concerning it and by calling upon the public to uphold the hands of their public officials in what they are endeavoring to do along this line.

A WELL DESERVED TRIBUTE

Dr. Edward N. Brush of Baltimore, editor of the American Journal of Psychiatry, professionally known as the "Dean of American Psychiatrists," paid a high tribute to Governor Smith in accepting an invitation to the dedicatory ceremonies of the Veterans' Memorial Hospital at Kings Park, September 24, 1927.

In his letter to Matthew J. Tobin, President of the Board of Managers, Dr. Brush said:

"I have long been anxious to see the Kings Park State Hospital, and I have a very special desire to see and hear Governor Smith who, in my opinion, has shown a broader and more intelligent conception of the problems of the State hospital system and has done more to advance the cause of the

mentally disordered and defective in the State of New York than any of his predecessors within my recollection. I make this statement from a pretty intimate acquaintance with the conduct of the State hospitals, extending back half a century."

THE COURT CLINIC

"Science and psychiatry instead of steel and force point the way toward prevention of crime," said Judge William Allen of the Court of General Sessions of New York City recently, according to the New York Sunday World. "The court clinic as conducted by the Neurological Institute for the last eighteen months has been of great service to me in determining the degree of mental responsibility of prisoners, and I hope that the clinic will be made a permanent feature as an adjunct to the criminal courts. Judges, probation officers and the Parole Board should have complete information regarding the mental condition of prisoners if they are to cope intelligently with delinquents and with the crime problem in general."

PSYCHIATRIC HOSPITAL AT SYRACUSE

State Architect Sullivan W. Jones is preparing plans for the State Psychiatric Hospital at Syracuse which is to be built next year. The cost is to be met out of the $300,000 bond issue allotment made by the last Legislature. The new hospital which will be operated in cooperation with the Syracuse hospital and Syracuse University will be a research and teaching center and will treat incipient mental disorders.

COMMITTEE ORGANIZED FOR MEMORIAL TO DR. SALMON

A committee has been formed to prepare a memorial to Dr. Thomas W. Salmon, professor of psychiatry at Columbia University, and the first medical director of the National Committee for Mental Hygiene, who, in August was drowned while sailing on Long Island Sound.

The chairman of the committee is Dr. Frankwood E. Williams, medical director of the National Committee for Mental Hygiene, and the treasurer, Dr. Samuel W. Hamilton, assistant medical director, Bloomingdale Hospital, White Plains. The function of the committee is to consider plans proposed for a memorial and to receive funds for this purpose.

Other members of the committee are: Dr. George S. Amsden, professor of psychiatry, Union University; Dr. A. A. Brill, New York University; Dr. Sanger Brown, II, assistant commissioner, State Department of Mental Hygiene; Dr. Louis Casamajor, professor of neurology, Columbia University; Dr. Thomas K. Davis, assistant professor of Psychiatry, Cornell Uni-

versity; Dr. Menas S. Gregory, director, Psychiatric Pavilion, Bellevue Hospital; Dr. C. Floyd Haviland, medical superintendent, Manhattan State Hospital; Dr. J. Ramsay Hunt, adjunct professor of neurology, Columbia University; Dr. Smith Ely Jelliffe, editor, Journal of Nervous and Mental Diseases, New York; Dr. George H. Kirby, director, State Psychiatric Institute, Ward's Island, New York; Dr. Charles I. Lambert, associate professor of psychiatry, Columbia University; Dr. Sylvester R. Leahy, Brooklyn, New York; Dr. Mortimer W. Raynor, medical director, Bloomingdale Hospital; Dr. Wm. J. Tiffany, medical superintendent, Kings Park State Hospital; Dr. Edwin G. Zabriskie, attending neurologist, Neurological Institute, New York; Dr. Clarence O. Cheney, medical superintendent, Hudson River State Hospital; Dr. William C. Garvin, medical superintendent, Binghamton State Hospital; Dr. Milton A. Harrington, consultant in mental hygiene, Dartmouth College.

NOTES

—Ground was broken for the new building of the Neurological Institute of New York at the medical center October 19, 1927.

—Dr. Dean Lewis of Baltimore and Dr. John B. Walker of New York City, distinguished surgeons, have recently been appointed members of the Medical Council of the United States Veterans' Bureau.

—A so-called intelligence test for parents prepared by Dr. Bess V. Cunningham of Teachers College, Columbia University, is being distributed by the State Charities Aid Association of New York City. The test in reality is an examination in the elementary principles of child management.

—The Fourth Annual Conference of Special Agents of the Department of Mental Hygiene was held in the office of the Commission at Albany, October 13, 1927. Addresses were made by Commissioner Parsons, Deputy Attorney General George V. Fleckenstein, and papers were presented by John L. Warner, Harry Sylvester and Frank P. Hoffman, special agents of the Department. John F. O'Brien, head of the Collections Bureau, presided.

—A clinical conference will be held by the Department of Mental Hygiene at the Syracuse State School, Syracuse, Friday, October 28, 1927. The program will consist of papers dealing with the preventive field of psychiatry, particularly as related to clinics for children, and with the medical work of the State schools and hospitals.

—Dr. Vernon C. Branham, psychiatrist in the Division of Mental Defect and Epilepsy of the Department of Mental Hygiene, resigned September 1, 1927, to become medical director of the New York State Committee on Mental Hygiene of the State Charities Aid Association.

For several years, through the organization and direction of clinics for retarded and defective children, Dr. Branham had rendered notable service to the Department and to the people of the State.

—A 40-piece band, the members of which are nearly all patients of the Jacksonville (Ill.) State Hospital, furnished music for one day (September 8, 1927) at the Sparta (Ill.) Fair. The same band won first place in competition with several other bands at the State convention of the American Legion at Joliet this year. The leader of the band is Bernard H. Strongman, a well-known musician, who was formerly a member of the royal band of England.

—The New York Chapter of the American Association of Psychiatric Social Workers has organized an advanced course in mental hygiene. Dr. Kenworthy is leading this course, which is being held at the New York School of Social Work. The group is made up of graduates from the Smith School of Social Work and the New York School of Social Work and includes staff

members from the National Committee for Mental Hygiene and various local psychiatric clinics.

—Construction is proceeding rapidly on the new $3,000,000 neuropsychiatric hospital being built by the United States Veterans' Bureau at Northport, L. I. This hospital will have a capacity of 1,000 patients when completed. Its construction involves the erection of 27 buildings on the 561-acre reservation. About 800 men are being employed on the work which is about 50 per cent completed.

—A special systematic class for post-graduate study in neurology and psychiatry will be held during the months of January and February, 1928, at the Neuropsychiatric Clinic of Professor Wagner von Jauregg and the Neurological Institute of Professor Marburg, Vienna University, Austria, under the auspices of the American Medical Association of Vienna. The instruction and the lectures in the course are to be in English. A minimum of eight students is required in order to have the course given. The maximum number admitted will be 15.

—The annual meeting of the American Occupational Therapy Association was held in conjunction with the meeting of the American Hospital Association at Minneapolis, October 10-12, 1927. The principal themes for discussion were "Occupational Therapy for Children", "Occupational Therapy and Mental Disease", and "Occupational Therapy in Industrial Accident Cases." In addition, important reports of committees were submitted.

—The Mental Hygiene Committee of the Onondaga Health Association has arranged a course of eight lectures on the "Mental Hygiene of Normal Childhood" to be given in the ballroom of the Onondaga Hotel on Thursday evenings from October 13, to December 8, 1927. The speakers and subjects will be as follows:

"Your Mind and You", by George K. Pratt, M. D.

"Heredity and Environment as a Basis for Mental Health", by Abraham Myerson, M. D.

"Habit Training for Young Children", by Lawson G. Lowrey, M. D.

"Relationships Between Parents and Children", by Esther L. Richards, M. D.

"Special Abilities and Disabilities", by Augusta F. Bronner, Ph. D.

"The Delinquent Child and the Delinquent Community", by Ira S. Wile, M. D.

"Mental Hygiene in the School", by Marion E. Kenworthy, M. D.

"Special Problems of High School Years", by Arthur H. Ruggles, M. D.

REVERSE PERISTALSIS AND INDIGESTION

"THERE is accumulating evidence," asserts a distinguished authority on nutrition, in his book on dietetics, " . . . that a very slow, almost imperceptible reverse peristalsis is an exceedingly common phenomenon and is the real cause of a majority of the symptoms associated with the stomach. . . . Chronic constipation, or intestinal stasis, is thus being shown to be the cause of most of the disorders of the alimentary canal as well as the origin, through intestinal toxemia, of a vast number of general disorders."

Thanks to the continuous educational work of thousands of physicians and dietitians, there are today many evidences of a growing realization of this cause and effect relation between chronic constipation and disorders of the stomach. Not the least of these evidences is the place which fresh yeast has come to occupy in the nation's diet.

Although known to the medical profession for years—it was in 1852 that Mosse, writing in the London Lancet, first called yeast to the attention of the medical world—it is only within the past 15 or 20 years that fresh yeast has come into its own as a corrective food in the treatment of constipation and allied disorders. During this period the researches of many men in the very front rank of medical science, both in this country and in Europe, have fully corroborated the findings of Mosse and other earlier workers.

The mass of authoritative data, both laboratory and clinical, which these researches have yielded, has made increasingly plain the many advantages of fresh yeast in treating disorders having their source in an unhealthy condition of the colon. One of the greatest of these advantages is the effect of yeast in setting up conditions unfavorable to the development of hostile bacteria in the intestine.

In constipation, yeast tends to increase the bulk and moisture of the fecal masses. The stools become more easy and regular. The toxemia resulting from prolonged cases of intestinal putrefaction ceases to be a symptom.

Directly the whole digestive tract is benefited. Appetite increases, and with it the patient's sense of well-being.

In run-down conditions yeast has a mild systemic effect. In skin affections, such as furunculosis and acne, the efficacy of fresh yeast is too well known to call for comment.

• • •

Physicians usually suggest three cakes daily, one before each meal. Yeast may be eaten plain or with a sprinkle of salt, spread on crackers, or suspended in milk or water. For constipation it is most effective when taken in hot (not scalding) water, one cake before each meal and at bedtime.

A copy of the latest brochure on yeast therapy, containing a bibliography of articles and references on the subject, will gladly be mailed on your request. The Fleischmann Company, Dept. 100, 701 Washington Street, New York City.

INDEX TO VOLUME I

OLD SERIES VOL. XII